DANCE/MOVEMENT THERAPY AND THE PSYCHOSOCIAL WELL-BEING OF LEARNERS WITH VISUAL IMPAIRMENT: A CASE STUDY

by

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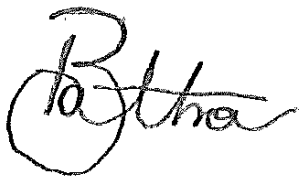

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ABSTRACTS

ENGLISH

This transformative mixed method case study investigated the influence of Dance/Movement Therapy (DMT) as a physical activity on the psychosocial well-being of learners with the visual impairment of low vision in a school for the visually impaired in Gauteng. A study of existing literature indicated a series of psychological and social dynamics which shape a person with low vision's self-esteem and subsequent psychosocial well-being. A DMT intervention programme was designed accordingly. Through a filtering process, six female, adolescent participants with possible self-esteem challenges were identified. These participants completed the Rosenberg Self-Esteem Scale (RSES) prior to taking part in the eight 60 minute sessions of the DMT intervention programme. The RSES was completed again post-intervention. Results indicated an increase in the self-esteem levels of all six participants to various degrees. Qualitative measures, including observations schedules, process notes in a researcher's diary and participant reflections in DMT Journey Journals supported quantitative findings.

KEY TERMS

Physical impairment; sensory Impairment; visual impairment; low vision; self-esteem; psychosocial well-being; physical activity; psychological functioning; social functioning; micro and macro systems; Dance/Movement Therapy; range and quality of movement; use of space; patterns of movement

SETHSWANA

Tshosobano

Mokgwa o, o o tswakantseng was diphetogo wa dithuto o batlisitse thotloetso ya Motantsho/ Motsamao wa pholo jaaka ikatiso ya mmele mo go itekanelong/ boitekanelong jwa tlhaloganyo ya barutwana ba ba sa boneng sentle mo sekolong sa bana ba ba sa boneng mo kgaolong/ porofinsi ya Gauteng. Dipatlisiso tsa dikwalo tse di leng teng di supa tatelano ya tlhaloganyo le loago e e farologaneng e e bopang go tlhoka go itshepa ga motho yo a neng le pono e e bokowa le tlhaloganyo le botho jwa gagwe. Ka jalo lenaneo la tseregano la DMT le ile la diriwa. Ka mokgwa wa go tlhopha, makgarebe a baša a le marataro, a a nang le mathata a go tlhoka boitshepo a ile a tlhopiwa. Ba tsaya karolo ba ba ile ba tlatsa kgotsa ba konosetsa selekano sa boitshepo sa Rosenberg (RSES) pele ba tsaya karolo mo go lenaneong la dikarolo tse robedi tsa metsotso e le 60 ya tserenanyo ya DMT. Morago ga tsereganyo selekano se ile sa tladiwa gape. Dipholo di supile kgolo e e farologaneng ya boitshepo mo go batsayakarolo botlhe ba le barataro. Ditekanyetso tsa boleng, tse di akaretsang lenaneo la ditlhokomediso, dintlha tsa tiriso tsa letsatsi le letsatsi mmatlisisi le maikutlo a batsaakarolo di totobatsa dipholo tse.dintsi mo dikwalong tsa tsela ya DMT.

AFRIKAANS

Opsomming

Die invloed van die fisiese aktiwiteit van Dans/Bewegingsterapie op die psigososiale welstand van leerders met lae visie in ‘n skool vir gesiggestremde leerders in Gauteng is deur hierdie transformatiewe gemengde metode gevallestudie ondersoek. ‘n Studie van bestaande literatuur het ‘n reeks sielkundige en sosiale faktore wat die persoon met lae visie se self-beeld en gevolglike psigososiale welstand vorm uitgelig en ‘n Dans/Bewegingsterapie intervensieprogram is daarvolgens ontwerp. Ses vroulike adolesente deelnemers met moontlike self-beeld uitdagings is deur middel van ‘n filtreringsproses geïdentifiseer. Hierdie deelnemers het die Rosenberg Self-Esteem Scale (RSES) voor en na hulle deelname aan 8 60 minute sessies van die Dans/Bewegingsterapie intervensieprogram voltooi. Resultate het onderskeidelik ‘n toename in selfbeeldvlakke van al ses deelnemers tot in verskillende mates aangedui. Kwalitatiewe maatstawwe soos die gebruik van obserwasieskedules, prosesnotas in ‘n navorserdagboek en deelnemers se refleksies in hulle persoonlike Dans/Bewegingsterapie joernale het die kwantitatiewe bevindinge ondersteun.

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LIST OF ABBREVIATIONS

AM	Authentic movement
BMC	Body and Mind Centring
CA	Creative Arts
CAPS	Curriculum and Assessment Policy Statement
DBE	Department of Basic Education
DMT	Dance/Movement Therapy
DOE	Department of Education
ICF	International Classification of Functioning, Disability and Health
ICF-CY	Classification of Functioning, Disability and Health for Children and Youth
ICIDH	International Classification of Impairments, Disabilities and Handicaps
LMA	Laban Movement Analysis
MARA	Movement Assessment and Reporting App
NCPPDSA	National Council for People with Physical Disabilities, in South Africa
PE	Physical Education
PSW	Personal and Social Well-being
RSES	Rosenberg Self-Esteem Scale
SE	Self-esteem
SC	Self-confidence
SL	Self-liking
WHO	World Health Organization

CHAPTER 1

INTRODUCTORY ORIENTATION, STATEMENT OF THE PROBLEM, AIM OF THE STUDY AND CLARIFICATION OF CONCEPTS

1.1 INTRODUCTION

"I love dance, because it's the words I cannot speak."

- Unknown

In her book, *The story of my life*, the inspiring writer, political advocate and lecturer, Helen Keller (1880 – 1968), who was blind and deaf, tells of how sensory impairment is not indicative of a person's ability (Keller, 2009: 16). She has been quoted as saying that sense of sight and touch cannot substitute for what is felt in the spirit; that life loses meaning without courage and enterprise (Keller, 2009: 257). She did not make light of the fact that there is much affliction in the world, but chose to place emphasis on the equal degree of triumphs which arise from such challenges. She considered these trials as the building blocks of character – cultivating strength, inspiration and success (Keller in The Clergy of Christ Episcopal Church, 2010: 139).

She called for perseverance by proving that aspects which initially seem demanding become effortless with ongoing endeavour and believed that sanguinity, hope and confidence constitute the foundation of success (Keller in Haun, 2009: 75). Although she admitted to not being capable of all, she was committed to doing that which she was competent in doing and emphasised how much more can be achieved in collaboration with others (Hermann, 1999: 222). Helen Keller considered self-pity as the most significant barrier to reaching one's true potential (Keller in Haun, 2009: 65) and stated the following in her address to the American Heart Association to promote the teaching of speech to the deaf: "One can never consent to creep when one feels an impulse to soar" (Keller in Guthrie, 2003: 75).

Keller therefore suggests that human beings possess the ability of transcendence – where our spiritual dimensions of thought and feeling are able to overcome the limitations set by our physical being. This implies that, although a sensory impairment such as loss of vision might contextually be considered as a limitation, the degree of an individual's cognitive, emotional and social well-being holds the potential to enable him or her to rise above such restrictions (Smart, 2011: 131). In addition, Martins (2014: 51) also refers to the interaction

between physical, psychological, and social well-being and the subsequent quality of life. She views physiological limitations as creating areas for continuous growth in psychological and social welfare.

According to Vash and Crewe (2004: 155), the first step to transcendence of impairment is to cease to consider a person's body, mind and environment as separate entities. Smart (2011:130 – 132) adds to this by referring to Maslow's (1970) concept of self-actualisation which is reached by attending to the physical (managing the impairment), psychological (accepting the impairment) and the social (taking on a functional and meaningful role in society regardless of the impairment). This seems to suggest that self-actualisation requires the fulfilment of physical, psychological and social needs. Maslow (1970, as cited by Smart, 2011: 130) elaborates on the above by explaining that persons with impairments reach a point of transcendence above their physical limitations through peak experiences. Peak experiences are described as moments of creative possibility and spontaneous surrender; instances where ability and a sense of belonging become apparent; encounters which lead people who initially considered themselves broken to feel whole – occurrences where the aforementioned physical, psychological and social needs are met.

McNutt (2012: 282) describes expressive art therapy sessions to be opportunities for igniting creativity, bringing forth catharsis and transformation, finding hope and potential, introspection and self-learning, active engagement with others and for healing. It is therefore considered to be an approach which engages the physical, psychological and social components of the individual (McNutt, 2012: 283). Consequently, it seems possible that expressive art therapies might be considered as a plausible means of creating the aforementioned peak experiences as a means of therapeutic intervention in order to facilitate persons with sensory impairments to reach the point of transcendence as Helen Keller proposed (Keller in Guthrie, 2003: 75).

1.2 BACKGROUND TO THE PROBLEM

According to Malchiodi (2005), each person prefers and incorporates a different expressive manner or technique, the choice of which is based on sensory preferences. In acknowledgment of this, expressive art therapies have been founded, developed and employed as a means of facilitating efficient and genuine communication (Malchiodi, 2005: 1). Expressive art therapies refer to a field of psychotherapy, counselling, rehabilitation and health care which incorporates art, music, dance/movement, drama and creative writing as means of treatment (Malchiodi, 2005: 2). It is based on the premise that opportunities to

express oneself through expressive art –whether it be dance/movement, visual art, drama, music or a combination of these – enable a person to learn more about themselves, communicate through non-verbal means and gain intra- as well as inter-psychic understanding (Malchiodi, 2005: 3).

Farrely-Hansen (2001: 18) writes about the connection between spirituality and art therapies, suggesting that transcendence of the physical self occurs through the growth of one's soul, and is brought about by the freedom and expressiveness that the creative nature of the arts embraces. To promote the psychosocial nature of the expressive art therapies, she writes about how self-acceptance (Farrely-Hansen, 2001: 182) and a sense of community (Farrely-Hansen, 2001: 204) are promoted through this form of therapeutic intervention, and that the potential for transcending bodily and/or environmental states lies in this. A recent qualitative study done by Diamond and Lev-Wiesel (2016: 401) had adults who had partaken in expressive art therapies as children recall their experiences with regard to this therapeutic intervention and found that their most pertinent recollections were focussed on their personal ability to engage in various creative situations as well as the empathetic, harmonious and secure surroundings provided within this therapeutic setting.

Johnson (2001: 12) specifically considers dance/movement as an expressive art therapy which is securely based on the concept of physical, psychological and social integration:

> "This fundamental premise sees the body and our relationship to it as key to personal and social transformation" (Johnson, 2001: 12).

As argued in the introduction section of this chapter, it seems that transcendence requires not only the promotion of physical functioning but also psychological and social (psychosocial) development. McCarthy, Hall, Crawford and Connelly (2017: 854) also outline the process of self-transcendence as including a psychosocial combination of mindfulness training, group activities, creative engagement and physical exercise. The term psychosocial suggests that not only emotional but also communal aspects should be considered along with a person's bodily health, as the interrelation of social factors as well as individual thought and behaviour determine an individual's state of being (Newman & Newman, 2014: 61).

DiNapoli, Garcia-Dia, Garcia-Ona, O'Flaherty and Siller (2014: 295) studied the relation between transcendence and the promotion of psychosocial well-being and found that it is an effective means of coping with and accepting physical and environmental challenges, which

promotes wellness on a psychological and social plane. This can be explained by the fact that dance/movement is not merely a bodily happening which improves the muscular and cardiovascular systems (Goodwin, 2008: 18). Cognitively, it develops motor planning and sequencing, creating a greater understanding of one's physical presence and spatial relations, and through dance/movement a consciousness of how a person responds emotionally to various states is expedited (Goodwin, 2008: 19). The fact that dance/movement is usually presented in a group format also provides opportunity for social development (Goodwin, 2008: 20). According to Lieberman and Houston-Wilson (1999: 130), individuals with sensory barriers such as visual impairment hold the same degree of capacity for developing the above-mentioned physical, cognitive, emotional and social skills should they be presented with the opportunity, and dance/movement is considered to be one such opportunity (Halprin, 2003: 83).

Dance/Movement Therapy (DMT) is considered a curative and restorative method of therapy which integrates the aforementioned physiological, psychological and social processes in order to facilitate individual modification and advancement through the means of dance/movement by combining manageable exertion, music and sensory stimulation (Levy, 1988: 17; Goodill, 2005: 15; Malchiodi, 2005: 2; Payne, 2006: 3; Chaiklin & Wengrower, 2016: 3).

Lieberman and Houston-Wilson (1999: 129 – 138) express and explain the need for persons with sensory impairments to participate in any physical activity which requires the movement of one's body as a means of expending energy through increasing the resting heart rate. Cleary (2002: 29) writes on how the loss of a sense such as vision can affect the sensory integration process, influencing a person's cognitive-motor development and subsequent self-esteem. Morse (2004: 43 – 54) reports on the various possible interrelated psychological and social challenges which individuals with sensory impairments – specifically low vision – might face in day to day functioning.

Therefore, it seems that Dance/Movement Therapy may be applied to address the above-mentioned physical, psychological and social barriers that persons with sensory impairments might experience, as Dance/Movement Therapy's psychosocial nature incorporates a person's body, feelings, thoughts and social interactions to bring about change on physical, psychological and social levels (Cutter, Shiflett & Kuo, 2005: 469). To further advocate the above statement, Murdoch (2013: 2), reports on the stereotypical movements which children with sensory impairments tend to execute as a means of adapting to environmental challenges and how the replication and expansion of such movements can assist in

advancing psychological growth and social interaction.

This study aims to investigate the relevance of the above for adolescents with low vision who participate in a Dance/Movement Therapy intervention programme. Adolescents with low vision refers to children between the ages of 10 and 18 (Wolman, 1998: 2; Steinberg, 2014: 1 – 3), who have experienced significant loss of vision due to hereditary deficiency, disease or injury, to the extent of it presenting challenges in their daily functioning (Leat, Legge & Bullimore, 1999: 200).

1.3 ANALYSIS OF THE PROBLEM

1.3.1 Initial awareness

Initial awareness originated from the researcher's personal background in dance as a performance art, but more specifically from her familiarity with its expressive, unburdening and subsequent therapeutic potential. The researcher was then introduced to the notion of deliberately applying dance/movement for educational purposes when taking part in a teaching and training programme where dance as a performance art was applied as a means of imparting Christian-based norms and values. What inspired the researcher to pursue this topic however was designing and presenting dance/movement workshops as part of holiday programmes for underprivileged communities. The researcher then started teaching hip hop dancing to learners with sensory impairments (visual and auditory) and has subsequently witnessed the enjoyment of dance/movement by such learners first hand.

Finally, working as an educator at a school which caters for learners with visual impairment, the researcher also became mindful of the absence of opportunities for engaging in physical activities within the visually impaired environment and how cultural activities, especially singing and playing musical instruments, are employed as a means to compensate for this. This made the researcher deliberate about the prospect of establishing a Dance/Movement Therapy intervention programme founded on the learners' enthusiasm for rhythm and music. All of the above contributed to a cognisance of and inquisitiveness about this subject and has subsequently served as motivation for this particular research study.

1.3.2 Exploration of the research field

An overview of relevant literature on the implementation of Dance/Movement Therapy yielded the following results:

The positive correlation between being active and the emotional and social advantages physical activity yields for the general population has been researched to a significant extent (Fox, 1999: 411; Pender & Wu, 2002: 25; Penedo & Dahn, 2005: 190; Guthold, Stevens, Riley & Bull, 2018: 1077). The fact that dance/movement implies engagement in physical activity (Meekums, 2002: 3) may suggest that Dance/Movement Therapy could produce similar benefits. In fact, Meekums (2002: 4) encapsulates the field of Dance/Movement Therapy as follows:

> "DMT is defined as the psychotherapeutic use of movement and dance through which a person can engage creatively to further their emotional, cognitive, physical and social integration."

Dance/Movement Therapy (DMT) is practised in a wide variety of settings including in rehabilitation and medical centres, by the mental health professions, as well as in educational and forensic situations, and can also be incorporated in disease prevention and health promotion programmes (Levy, 1988: 50; Goodill, 2005: 16; Payne, 2006: 31-70; Farrel, 2012: 81; Chaiklin & Wengrower, 2016: 3). In a recent article published in the *American Journal of Dance Therapy*, Goodill (2016: 293) elaborates on the significant role which Dance/Movement Therapy has played in the "arts in health care movement" in the past 50 years. Benefits of this therapeutic intervention include health promotion linked to fitness, advancement of motor skills and range of motion, better spatial awareness, decrease in muscle tension, pain reduction, reduced levels of anxiety, improved body image and self-esteem, decline in feelings of isolation, development of communication skills and an overall sense of wellness brought about by the release of endorphins (Alpert, 2011: 155 – 157). These advantages again highlight that dance/movement as an expressive art therapy is not simply a bodily activity which strengthens a person physically, but that it promotes psychosocial development as well.

In further support of the above, Dance/Movement Therapy has been proven to be an effective means of intervention for individuals with developmental, medical, social, physical and psychological impairments and can be practised by people of all ages, races and ethnic backgrounds in individual, couples, family and group therapy formats (Payne, 2008: 21). Therefore, as mentioned above, the conception that Dance/Movement Therapy may be associated with the advancement of psychosocial well-being seems plausible.

As defined in section 1.2 of this chapter, psychosocial well-being refers to the close connection between an individual's thoughts, emotions and behaviour and the manner in

which he/she experiences these aspects within his/her wider social system (Newman & Newman, 2014: 61; Koen, Van Eeden & Rothman, 2012: 344). When one considers the definition of well-being, this connection between physical, psychological and social development becomes even more apparent. Well-being refers to a condition of holistic health in all its dimensions including physical, emotional and social (Koen, Van Eeden & Rothman, 2012: 343).

As has been mentioned in previous sections, adolescents with low vision experience not only the challenge of access to physical activities (Lieberman & Houston-Wilson, 1999: 129), but also face an array of psychosocial challenges (Morse, 2004: 43). For this reason, this study aims to investigate whether the proven positive impact that physical activity has on the general population's psychosocial well-being (Fox, 1999: 411; Pender & Wu, 2002: 25; Penedo & Dahn, 2005: 190) can be applied to adolescents with low vision by creating the much needed opportunity for the participants to engage in physical activity through participating in a Dance/Movement Therapy intervention programme, and thereby possibly developing the psychological and social dimensions which enable these individuals to transcend the limitations of their primary impairment.

Seeing as psychosocial well-being is a broad and encapsulating term which includes various psychological and social facets, including self-concept, body image, communications skills, social roles and solidarity, level of independence and mastery etc. (Mwamwenda, 2004: 298), the researcher will focus on an element which is interrelated with, and determinant of, all these other elements: i.e. self-esteem (Morse, 2004: 44).

According to Baumeister (1998, as cited by Heatherton & Wyland, 2003: 220), a person's self-esteem is the evaluative component in determining one's psychosocial well-being. Baumeister highlights the psychological and social composition of self-esteem by referring to Coopersmith's (1967) description thereof: "The self-esteem is an expression of an attitude of approval or disapproval which determines the degree in which a person believes in his/her capability, significance, success and worth". Therefore, as an attitude of the self, self-esteem is associated with personal beliefs about skills, abilities, social relationships and future outcomes. Thus, when one refers back to the composite elements of psychosocial well-being (Mwamwenda, 2004: 298), the self-esteem's significant role in determining a person's psychosocial well-being is clearly professed (Heatherton & Wyland, 2003: 221).

In support of the above, Paradise and Kermis (2002: 345) also examined the extent to which self-esteem is a predictive element of psychosocial well-being and found that high self-

esteem was more associated with greater psychosocial well-being than was low self-esteem. Dogan, Totan and Sapmaz (2013: 31) also found a positive and significant relationship between self-esteem, psychosocial well-being and subsequent happiness as the person with a higher level of self-esteem believes in his/her abilities and is more likely to engage actively in physical activities and interact socially. This interrelation of the physical, psychological and social suggests that transcendence of physical limitations is indeed plausible as the physiological is clearly by no means an island. To support this concept further, Corteville (2009: 49) investigated this connection between the physical, emotional and social by implementing a Dance/Movement Therapy intervention programme with a group of 15 year old females within a school setting and determined that their participation led to an improvement in self-esteem and communication skills.

1.3.3 Rationale of the study

1.3.3.1 Based on policy

The Curriculum and Assessment Policy Statement (CAPS), which is the system of learning and teaching currently being followed in South African schools, includes the subject of Life Skills, which in itself consists of three study areas, namely Personal and Social Well-being (PSW), Creative Arts (CA) and Physical Education (PE) (South Africa. Department of Basic Education, 2011: 7). The combination of these three study areas, which culminates in a subject that is taught from Grade 1 to Grade 12, further suggests that there is a significant link between engaging in physical activity and developing emotionally and socially and that creativity is interrelated with the former and the latter areas of growth as was proposed by McNutt (2012: 282 – 283) and Malchiodi (2005: 3), as previously mentioned. The following quote from the subject policy document supports this conception:

> "Life Skills is central to the holistic development of learners. It addresses skills, knowledge and values for the personal, social, intellectual, emotional and physical growth of learners, and is concerned with the way in which these facets are interrelated" (South Africa. Department of Basic Education, 2011: 7).

With regard to persons with impairment – physical, sensory or otherwise – South Africa aims to promote an inclusive education system based on the goal of including persons with impairments in the workplace, social sphere, political environment and sports arenas (South Africa. Department of Education, 2001: 10). In theory it aims to establish an integrated, tolerable and democratic society, but according to Prinsloo (2001: 344) and Donohue and Borman (2014: 1), in practice there are ambiguous policy guidelines, insufficient educator training and support, societal and cultural beliefs about impairment, as well as financial and

infrastructural constraints, which hinder the full implementation of this ambition.

Although still considered a special school due to its admission criteria, which are based on a certain degree of visual impairment, the school where this particular research will be conducted serves as a resource centre which provides guidance, support and training to other mainstream schools that accommodate learners with visual impairments, and also follows the mainstream curriculum itself. This means that learners with low vision as well as their blind peers are therefore educated in the subject Life Skills – including the study area of Physical Education. However, the fact that, according to the Life Skills Subject Policy (South Africa. Department of Basic Education, 2011: 10), only 1 hour per week is dedicated to physical activity as well as the previously mentioned fact that few other physical activities are presented as extra-mural activities is worrisome, as the recommended degree of physical activity for an adolescent is 1 hour per day – in others words 7 hours per week (Trost, 2006: 168; United States. Department of Health and Human Services, 2008; Shennar-Golan & Walter, 2018: 1530).

As stated in previous sections of this chapter, Lieberman and Houston-Wilson (1999: 129) also report on the lack of and need for engagement in physical activities for adolescents with low vision. Furthermore, Huurre and Aro (1998: 73) found that adolescents with low vision were less likely to form friendships or romantic relationships than their counterparts with a normal range of vision. It was also determined that adolescents with low vision – especially girls – reflected lower self-esteem and poorer social skills than their peers who did not experience visual difficulties and that girls with low vision subsequently require a greater degree of support in their psychosocial development (Huurre & Aro, 1998: 74).

Sacks (2010: 69) also writes about how an individual with low vision's identification with, as well as understanding and acceptance of, his/her sensory challenges can have an impact on his/her self-esteem and ability to interact socially. Morse (2004: 50) further explains that a person with higher self-regard and stronger peer-group relationships is more capable of successfully adjusting to having low vision. Thus the physical and psychosocial needs of adolescents with low vision are again professed in policy and practice.

1.3.3.2 Based on practice and existing research

Corn and Erin (2010: xiii) write, as part of an introduction to their book *Foundations of Low vision: Clinical and Functional Perspectives*, that the topic of low vision has broadened to a significant extent to tie medical, educational and rehabilitative services. Meeus (1994: 362) also calls for individuals with low vision to be supported by a multi-disciplinary team as these

individuals do not only require guidance with regard to sensory development and integration, but also with the development of self-esteem and social engagement. Morse (2004: 43) supports this by stating that a great number of individuals with low vision fail to successfully adapt to their condition due to the fact that the promotion of psychosocial well-being is not incorporated into their treatment plan.

This in itself suggests not only the connection between physical, psychological and social wellness, but also the possibility of an intervention such as Dance/Movement Therapy being effective in providing the aforementioned psychosocial support needed for adolescents with low vision to transcend their sensory impairment, as Dance/Movement Therapy has been described and classified as a psychosocial approach to intervention (Sandel & Kelleher, 2012: 26).

An extensive search of electronic journals and books in the largest library in Africa yielded limited research with regard to the psychosocial well-being of adolescents with low vision in South Africa. Authors who have written about this subject, however, are in agreement that contextual circumstances such as poverty, access to quality health care and support services, the availability, access to and affordability of assistive devices as well as differing cultural perspectives with regard to visual impairment, exacerbate the challenges as experienced by their first world counterparts (Mwamwenda, 2004: 337; Donald, Lazarus & Moolla, 2014: 285; Naidoo, Jaggernath, Ramson, Chinanayi, Zhuwau & Overland, 2015: 136; Naipal & Rampersad, 2018: 393).

Research within the Dance/Movement Therapy field has focused on benefits for cancer patients, learners with autism and attention deficit hyperactivity disorder, patients with depression and eating disorders as well as children from poor social economic backgrounds (Goodill, 2005: 87 – 123; Koch, Morlinghaus & Fuchs, 2007: 340; LeFeber, 2014: 463).

With regards to sensory impairments, Joanne Weisbrod (1974) initiated the application of Dance/Movement Therapy as a means of intervention with visually impaired clients whose social interactions were cautious and constrained due to the lack of assuring feedback received from visual input (Levy, 1988: 239). Fried (2013: 147 – 166) conducted two case studies which focused on how Dance/Movement Therapy can be applied to develop a more positive body image for blind children. Malling (2012: 12) cites Dance/Movement Therapists such as Oosterhaus (1985), Cohen (1990), Benari (1995) and Sherman (1997) as having researched and reported on the benefits of Dance/Movement Therapy for children with hearing impairments when combined with sign language, while she herself investigated the

use of Dance/Movement Therapy, choreography and performance techniques with deaf adults who suffer from mental illness. Therefore, although limited and conducted in American contexts, one can infer that the research conducted with regard to the use of Dance/Movement Therapy as a therapeutic intervention for persons with sensory impairments suggests that it is plausible to implement such an intervention programme with low vision adolescents within a South African context.

Although Dance/Movement Therapy, its effectiveness and applicability have been researched with various population groups and measuring a range of constructs, significantly less research has been completed within the South African context (Van der Merwe, 2010: 11). The following are examples of research studies regarding Dance/Movement Therapy which have been conducted in South Africa:

Wessels-Bloom (2008: 5) reported on the positive effect a Dance/Movement Therapy Programme yielded on the self-esteem of HIV-positive adolescents. Horn (2009: 139) used movement as part of Gestalt Therapy as a possible therapeutic intervention for adolescents with behavioural difficulties. Her research findings indicated that therapeutic movement brought about intra- and inter-psychic development in these adolescents. Scheffer (2009: 129) applied yoga movements as part of Gestalt Therapy to see whether it could promote awareness. Results indicate that participation in these movement sessions lead to improved self-awareness and trust within group interactions. With regard to research on dance/movement used as a therapeutic intervention for persons with impairments, Marais (2012: 121) conducted a case study that proved that wheel chair dancing improved the psychological and social functioning of learners with neurological impairments.

No research measuring the psychosocial functioning of South African adolescents with low vision who take part in a Dance/Movement intervention programme could be traced, but the fact that previous research studies have once again proven that Dance/Movement Therapy is linked to improved psychological and social functioning in various instances, led the researcher to consider whether the same could be said for a Dance/Movement Therapy programme conducted with South African adolescents with low vision. Furthermore, the fact that research on wheelchair dancing has found that dance/movement allowed South African learners with physical impairments to transcend their limitations by developing emotionally and socially, also encouraged the researcher to investigate whether a Dance/Movement Therapy programme would allow South African adolescents with low vision to transcend their sensory impairment through improved psychosocial well-being. Finally, the fact that research on Dance/Movement Therapy in general and more specifically Dance/Movement

Therapy with low vision adolescents in South Africa is limited, made the endeavour seem even more relevant.

1.3.3.3 Based on theoretical frameworks

Taking into consideration that the concept of transcendence is included in this particular study, the study will not aim to focus on the physical deficit of low vision, but rather on the potential emotional and social development which participation in a Dance/Movement Therapy intervention programme may bring forth, so as to rise above these sensory difficulties.

Imrie (1997: 263) states that impairment is more often than not viewed from a medical perspective, which places emphasis on the physiological ailment and therefore provides medical and/or physical support in an effort to improve quality of life. Such a model does not accommodate the possible role which emotional, social and environmental aspects can play in enabling (or disabling) an individual with a sensory impairment such as low vision (Imrie, 1997: 264). Various literature sources support the above by calling for a shift in viewpoint with regard to physical disability and its various sub-categories, including that of sensory impairment and more specifically low vision. Brittain (2004: 429) pleads for less emphasis on a medical paradigm and more focus on social frameworks.

Feedback from families of children with physical disabilities, including sensory impairments, affirm the call to examine physical and sensory challenges from a more social and constructive paradigm, as these families consider social aspects to be more limiting than the actual impairment itself (Law, Haight, Milrov, Willms, Stewart & Rosenbaum, 2011: 102). Goodley and Tragaskis (2006: 630) also recorded various families with physically and/or sensory impaired children as viewing the bodily limitations as surmountable with the necessary psychosocial intervention and support. Consequently, this research endeavour will be conducted within a social constructivism framework by working from a biopsychosocial model to investigate whether participation in a Dance/Movement Therapy intervention programme allows for transcendence of low vision through promoting emotional and social construction.

The shift in paradigm, as mentioned above, requires a framework which focuses on psychosocial development. In previous sections the psychosocial nature of Dance/Movement Therapy has been professed and Sandel and Kelleher (2012: 25) support this by proposing that when a Dance/Movement Therapy intervention programme places emphasis on psychosocial well-being rather than on the performance of the physical

activities themselves, an accepting atmosphere is created which places focus on ability rather than on the limitations of the impairment. As stated in previous sections of this chapter, Dance/Movement Therapy by definition does not consider an individual's development and consequent welfare as physiologically, psychologically or socially exclusive (Meekums, 2002: 4) and therefore it does promote Sandel and Kelleher's proposition.

In support of this call for a shift in paradigm, Koen, Van Eeden and Rothman (2012: 345) cite the Inter-Agency Network for Education in Emergencies (2011) as viewing emotional and social development being strongly connected due to the fact that the emergence of a child's experience, expression, understanding and regulation of feelings is influenced by his/her social context. An interaction between emotional, neurological, cognitive and behavioural development in cohort with social and cultural influences is therefore what brings emotional and social development about (Koen, Van Eeden & Rothman, 2012: 343 – 346). Schiller (2009: 12) further emphasises the relation between psychosocial and all other spheres of development, and therefore this study will consider the possibility of Dance/Movement Therapy creating the opportunity for adolescents with low vision to overcome the impediments which limited eyesight may present by propagating the holistic methodology of the association between the physical, emotional and social as the Department of Basic Education (DBE) proposes in White Paper 6 (South Africa. Department of Basic Education, 2001: 6).

Finally, the need for this is again professed by DeFue and Fergusson (2003: 95), Morse (2004: 45), Sacks (2010: 67), Papadopoulos, Montgomary and Chronopoulou (2013: 4565), Hooper and Umansky (2009: 356 – 358) and Ishtiaq, Chaudhary, Rana and Jamil (2016: 432), who all suggest that adolescents with low vision may experience psychological and social difficulties such as poor self-concept, inadequate self-expression and dysfunctional social interaction – all of which contribute to low self-esteem. In other words, the psychosocial aspects which are supposed to enable these learners to rise above bodily restrictions might be fraught with these very impediments.

1.4 PROBLEM STATEMENT

According to the Department of Health (South Africa. Department Health, 2013), physical activity promotes general healthy growth and development as well as the acquisition of fundamental motor skills. Consequently, it also ensures a strong cardio-vascular system,

muscles and bones, as well as improved movement, balance, coordination and reaction time. Healthy weight management and prevention against illnesses such as heart disease and diabetes are also consequent to being active. Physical well-being and mastering of skills promote a sense of self-worth and accomplishment (Petitpas, Champagne, Danish & Gullotta, 2000:115).Furthermore, physical activity assists in managing stress and anxiety and has been proven to reduce depression in children and youth. It promotes self-esteem and character development, while also enhancing intelligence and academic performance, and it reduces juvenile delinquent behaviour (Niemann, 2002: 310).

The challenge however, lies in the fact that, according to Guthold, Stevens, Riley and Bull (2018: 1077), participation in physical activity has declined significantly amongst today's youth – especially for those who have physical and/or sensory impairments (Lansdown, 2002; Longmuir, 2000: 40). For example, Inoue et al. (2018: 2) assessed the physical activity level of children and adolescents with visual impairment in Japan by employing the International Physical Activity Questionnaire and found that this group had a significantly lower level of physical fitness and a more sedentary lifestyle than their peers with a normal range of sight. There are various reasons for this, but the most pertinent of these is the fact that these children's need for physical activity and their ability to engage therein are grossly underestimated (Rimmer & Rowland, 2007: 145).

Research suggests that this lack of engagement in physical activity affects the psychological and social welfare of individuals with impairments in general and individuals with visual impairments specifically (Cooper et al., 1999: 142; Keeffe, 2005:167). The regularity and level of such activities as well as the individual's competence in executing them inadvertently influence his/her self-esteem and subsequent psychological and social well-being (Wahl, Schilling, Oswald & Heyl, 1999: 304). Craven and Marsh (2008: 104) echo this by explaining that bodily health is linked to positive self-esteem, which in return is associated with general psychological and social wellness. This implies that an absence of activity and consequent decrease in ability may impact on psychological aspects such as self-esteem and have a subsequent effect on social interaction. Morse (2004: 46) specifically confirms the pertinent role of physical activity for individuals with low vision by citing Davids (1959) as stating that participation in physical activity is a constituting factor in the formation of body image. Lack of participation in physical endeavours forms an inadequate body image. This distorts the individual's sense of self-esteem as a person performs according to what he/she believes to be true about him-/herself and his/her environment.

Therefore, various national governments and organisations have pleaded for more opportunities to engage children with physical disabilities (including sensory impairments) in physical activity:

> "The 1993 United Nations' *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* declares that member states should take measures to ensure that persons with disabilities have equal opportunities for recreation and sports" (Hannon, 2005: 3).

When one considers that, according to the National Council for People with Physical Disabilities, there are over 300,000 children in South Africa with physical disabilities, counting those with sensory impairments, it suggests that a great many opportunities for physical activity are lost, needed, or need to be created (NCPPDSA, 2013: 1). The need for engagement in physical activity is emphasised even further when one considers the above-mentioned statements, on how loss of physical activity and subsequent bodily ability lead to lower levels of self-esteem and social interaction – introductory statements in this study have already identified psychological and social dimensions as enabling individuals to transcend their physical and/or sensory limitations (Morse, 2004: 47).

Therefore, the research question for this study is as follows:
How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?

1.5 RESEARCH AIMS

1.5.1 General aim

The study aims to investigate how Dance/Movement Therapy influences the psychosocial well-being of six female adolescents with visual impairment.

1.5.2 Specific aims

Specific aims of this research endeavour will be to find answers to the following research sub-questions by conducting a literature study as well as an empirical study.

1.5.2.1 Research sub-questions

1. What will the Dance/Movement Therapy intervention programme entail?
2. How will an accepting environment which promotes ability be established?
3. How did the Dance/Movement Therapy intervention programme influence the participants' self-esteem and subsequent psychosocial well-being?

1.5.2.2 Literature study

An extensive literature study will be undertaken in order to acquire information with regard to adolescents with low vision, the challenges low vision presents, and how these adolescents construct themselves emotionally and socially. Literature on Dance/Movement Therapy will also be studied in order to determine whether and how Dance/Movement Therapy can be applied to guide adolescents with low vision in constructing positive emotional and social selves and in so doing improve their psychosocial well-being.

1.5.2.3 Empirical study

Field research will then be conducted through a mixed method approach by gathering data through pre- and post-intervention psychometric tests to determine levels of self-esteem as well as observation, process notes in a researcher's diary and participant reflections in personal DMT Journey Journals to report on overall psychosocial well-being.

1.6 CONCEPTUAL FRAMEWORK

- Dance: A configuration of movement in which components of the body or the body as a unit moves according to a rhythm or pattern which may or may not be accompanied by music (Payne, 2006: 3).
- Movement: Physical motion in which a person's body is shifted either by him/herself or by another individual to take on an altered posture or stance than was formerly maintained (Payne, 2006: 7).
- Dance/Movement Therapy (DMT): An approach to therapy which integrates physiological and psychological processes in order to facilitate personal alteration and progression through the means of dance/movement by combining manageable exertion, music and sensory stimulation (Goodill, 2005: 16).
- Dance/Movement Therapy intervention programme: A course or series of sessions planned and organised to accommodate a particular population group and founded on the ideals, principles and objectives of Dance/Movement Therapy (Corteville, 2009: 7 – 8).
- Physical disability: A controversial term, which is constantly evolving with human rights movements. For relevance to this study, it refers to challenges in the functioning of bodily systems, which include neurological, muscular and sensory difficulties (Donald, Lazarus & Moolla, 2014: 319).
- Sensory impairment: This term refers to discrepancies in the functioning of any of the five senses, but more often than not has to do with visual and auditory difficulties (Sacks, 2010: 67).

- Visual impairment: An umbrella term referring to individuals with low vision as well as individuals who are blind (Resnikoff et al., 2004: 844; Naipal & Rampersad, 2018: 393).
- Low vision: This refers to the decreased ability to see, which might be caused by a defect of the eyes, the optic nerve or the visual base of the brain which results in diminished visual perspicacity (Goodrich & Heubner, 2010: 35; Naipal & Rampersad, 2018: 394).
- Transcendence: The ability of the human psyche to overcome or rise above physical and/or environmental challenges (Smart, 2012: 131).
- Self-esteem: This can be translated as self-regard. In other words, the degree to which one believes in one's capabilities and consequent value (Fulmer, Gelfand, Kruglanski, Kim-Prieto, Diener, Pierro & Higgins, 2010: 1563).
- Psychosocial well-being: This implies the interrelation between social dynamics and personal judgements and conduct to the extent that the individual is able to realise his/her potential, can effectively manage conventional pressures of daily existence, can conduct constructive activities and play a meaningful role in his/her society (Newman & Newman, 2014: 61).
- Rosenberg Self-Esteem Scale: A 10-item scale which is used to measure a person's level of self-esteem by identifying positive and negative emotions about one's self-worth (Schmitt & Allik, 2005: 623).

1.7 RESEARCH METHODOLOGY AND DESIGN

A mixed method research approach will be employed in order to investigate this research problem as data collection will consist of qualitative methods in the form of observation, process notes in a researcher's diary and participant reflections in personal DMT Journey Journals, as well as a quantitative approach in the form of a psychometric measure. The choice of this particular methodology can be supported as follows:

Östlund, Kidd, Wengström and Rowa-Dewar (2010: 369) argue that due to the complex nature of the phenomena studied within the field of health and human sciences, a mixed method approach to research is quite informative. Regnault, Willgoss and Barbic (2018: 19) also suggest that a mixed method inquiry is the most suitable approach when researching health outcomes of any nature. Furthermore, mixed method research is considered to be a convergence of the assets and prospects of both qualitative and quantitative approaches

(Östlund, Kidd, Wengström and Rowa-Dewar, 2010: 370; Regnault, Willgoss & Barbic, 2018: 20). More specifically, convergent parallel mixed methods will be applied during the collection and interpretation of data. Creswell (2014:15) explains that the amalgamation of qualitative and quantitative data provides a more far-reaching analysis and subsequent comprehension of the research problem as it allows for inconsistencies and contrasting findings to be highlighted, investigated and explained.

This particular research endeavour is limited by time and activity and therefore a bounded case study will be employed to study the link between the phenomena of Dance/Movement Therapy and psychosocial well-being within the context of a school which caters for learners with the visual impairment of low vision. Baxter and Jack (2008: 544) consider this qualitative approach to research methodology as being ideal for expanding theories, assessing programmes and advancing interventions. As this study is concerned with whether the implementation of a Dance/Movement Therapy intervention programme for adolescents with low vision might possibly improve their psychosocial well-being, the researcher considered a bounded case study to be the most suitable method:

> "Case studies are a design of enquiry found in many fields, especially evaluation, in which the researcher develops an in-depth analysis of a case, often a programme, event, activity, process or one or more individuals" (Creswell, 2014: 14).

Gerring (2007: 2) strengthens the researcher's resolve to apply this form of research by stating that case study research is a dominant means of gathering, analysing and interpreting data within the fields of education, psychology, medicine and sociology, and that concentrating on an important particle can provide us with a better understanding of the whole which it constitutes. Since the sensory impairment of low vision and Dance/Movement Therapy fall within a medical and a psychological field respectively, and the adolescent with low vision's self-esteem and his/her consequent social functioning fall within the fields of psychology and sociology respectively, together with the fact that the research occurs within a school setting, a case study seemed an even more viable option.

Finally, as the research will be written within a constructivist framework, the choice of a bounded case study is further supported by the fact that case studies encapsulate the dynamics of the phenomenon being studied and, although it is executed within a specific context, it provides the researcher with a multi-dimensional observation of the situation being investigated. Similarly, constructivism is based on multiple-constructed, community-linked

realities and subsequently embraces the multiple views which a case study generates (Järvensivu & Törnroos: 2010:100).

1.8 DELIMITATION OF RESEARCH FIELD

The study will be limited to participants with low vision and therefore participants will be purposefully drawn from a school which specialises in providing education to learners with visual impairments. Only participants diagnosed with low vision by the school's nurse and ophthalmologist, and initially identified as having low self-esteem by the teachers and multi-disciplinary staff members of the school, will be included. The necessary facilities such as two separate school halls and apparatus including a music centre are also readily available at this institution.

According to Sandel and Kelleher (2012: 26) a group of no more than 12 participants increases therapeutic effectiveness as it encourages reflection, self-revelation and contribution. Therefore, the sample group will consist of 6 learners. Further the study will be demarcated to include only adolescent females between the ages of 13 and 17 so as to promote the homogeneity of the group and also to eliminate possible intervening factors such as heightened self-awareness and shyness. Should the 6 participants voluntarily agree to participate and their parents provide written consent of their children's participation, they will then be included in the study.

This particular Dance/Movement Therapy programme will be based on a combination of Authentic Movement (AM) – a version of Dance/Movement Therapy which was originally conceived by Mary Stark Whitehouse, where spontaneous movement is the result from an emotional impetus and is then reflected upon at the end of the session, and the projective technique of sensitisation, used by pioneering Dance/Movement Therapist, Blanche Evan, which stimulates structured movement that is based on the use of rhythm, space, flow and content by offering idiosyncratic images, stimuli and movement ordinances (Adler, 2002: 4; Levy, 1988:43). Lavendel (2016: 210) recently reflected on the holistic nature of Authentic Movement as it promotes psychological, physical and relational healing. In support of the researcher's choice of combining this approach with sensitisation, another innovator of Dance/Movement Therapy, Joanne Weisbrod, whose main focus was practising DMT with visually impaired individuals, also recommended the employment of multi-sensory experiences to stimulate both structured and unstructured movement in order to improve the body image of the participants (Levy, 1988: 133; Cleary, 2002: 50). Pylvänäinen (2018: 23) further explored the concept of body image within a DMT-framework, explaining that it is

conceptualised out of three elements: body-self, body-memory and image properties and how both the body-self as well as the body-memory are closely tied to sensory experiences, thus again professing the inclusion of sensitisation when employing this specific programme.

The collection of data will be completed by administering a pre- and a post-intervention psychometric measure as well as through observation, process notes recorded in a researcher's diary, and participant reflections in personal DMT Journey Journals. The psychometric measure which will be used is the Rosenberg Self-Esteem Scale (RSES). This quantitative and qualitative data will be amassed over the course of six weeks. During the first and the final weeks, the participants will complete the Rosenberg Self-Esteem Scale. During the four weeks in between, the participants will take part in the Dance/Movement Therapy intervention programme that will consist of eight 1 hour sessions which will be conducted twice a week. Throughout this time observation will be conducted according to an observation schedule and process notes will be noted in the researcher's diary.

As the approach of Authentic Movement, which partially serves as the foundation of this particular Dance/Movement Therapy intervention programme, calls for contemplation at the end of each session (Adler, 2002: 4; Levy, 1988:43), participant reflections will be written in personal DMT Journey Journals at the beginning and end of each DMT intervention session. Journaling refers to a method of data collection where participants impart their encounters, conceptualisations, emotions and deliberations through writing and is employed in qualitative investigations to document participant experiences in their natural environments (Hayman, Wilkes & Jackson, 2012: 27).

The rationale for using journals in the reflection, and subsequent data collection, process is based on the supplementary research question which considers how an accepting environment that promotes ability can be established, as well as on the call for such a secure environment to promote effective Dance/Movement Therapy (Payne, 2008: 35; LeFeber, 2013: 135). The researcher acknowledges the fact that due to their low levels of self-esteem, participants might not readily volunteer to share their thoughts, feelings and experiences out loud with the rest of the group and did not want to jeopardise the security of the environment by expecting verbalised reflections.

Bearing in mind that qualitative data analysis aims to organise, configure and denote the accumulation of data (De Vos, 2002: 339), the data gathered through observation will be analysed by studying the observation schedule, the process notes taken during and after

observation of each Dance/Movement Therapy session, and the participants' reflections in their personal DMT Journey Journals – first to gain an overview of each session as a whole, and then to identify possible themes or focus points in each session (Dey, 1993: 87; De Vos, 2002: 344).

The researcher will then start looking for recurring patterns (such as repetition of movements, movement preferences, use of shape and space etc.) as observed in the participants' movements and indicated on the observation schedule, as well as repetitive ideas or concepts noted in the process notes of the researcher's diary. Recurring patterns will also be sought in the participants' reflections during the eight respective sessions, which should link the participants and the Dance/Movement Therapeutic setting to create categories of meaning from the identified themes. Accumulated data will then be assigned to the created categories through a coding process (Dey, 1993: 100; De Vos, 2002: 344; Saldana, 2009: 8). The researcher will then present the processed data visually in tabular and figurative form to stipulate the relationships between the identified categories and produce an account of the data interpretations (Dey: 1993: 177-245; De Vos, 2002: 345).

With regard to the quantitative data gathered through the psychometric measure of the Rosenberg Self-esteem Scale, the numerical data will be explored by looking at each participant's scores on the Rosenberg Self-esteem Scale prior to the intervention, and then again after the eight Dance/Movement Therapy sessions (De Vos, Fouché & Venter, 2002: 242).

Finally, Williams (1995, as cited by Strydom, 2002: 74) summarised consent and assent as well as privacy and dignity to be key ethical considerations when engaging in the research process and will therefore serve as a guideline for the researcher when conducting the above-mentioned study:

Thorough contemplation will be given to possible risks and benefits of the research process for all participants involved. The researcher will ensure that assent is given by participants and that consent from their parents or legal guardians is provided on own volition. Both parties will be informed that no individual will be deprived in any way or penalised for refusal to participate. Participants who do agree to participate in the research study will also be asked, as the study progresses, whether they still want to continue with the Dance/Movement intervention programme. The participants' privacy and dignity will be upheld at all times by protecting the anonymity of each participant while gathering data and

when depicting and discussing the research results. Participants will be safeguarded from any possible and/or superfluous physical or mental discomfort, distress, harm, danger or deprivation by ensuring that the Dance/Movement Therapy intervention programme is adapted to accommodate any possible physical challenges. Discussion and evaluation of prospective participants with low self-esteem during the sampling selection process will only be engaged in with people directly and professionally involved and will be conducted in a professional manner. These individuals will also sign a confidentiality agreement (cf. Addendum M) to ensure that all information gathered concerning participants will be treated as confidential at all stages of the research process.

These stipulations are also supported by the Professional Code of Ethics and Unprofessional Business Conduct as set out by the Health Professions Council of South Africa. The researcher also obtained ethical clearance from the UNISA College of Education's Research Ethics Committee in order to comply with ethical considerations. Finally, the permission of the school principal, the school governing body, and the Department of Education (DOE) was also obtained.

1.9 PLAN OF STUDY

Chapter 1: Introductory orientation, statement of the problem, aim of the study and clarification of concepts

This chapter serves to orientate the reader by providing the background to this particular research study. In this section the reason for the selection of this specific topic is also explained. A literature overview serves to inform the reader about the chosen topic. Furthermore, the chapter outlines the research problem, method and aims, and also provides an explanation of the concepts used in writing up the research.

Chapter 2: Literature study

This chapter presents theoretical information concerning the following:

- Disability/impairment within a medical model
- Disability/impairment within a biopsychosocial model
- Types of impairment – physical, sensory, visual
- Defining low vision
- The causes and prevalence of low vision
- The psychosocial impact of low vision (with specific reference to the self, the micro and macro systems)
- Transcendence – with specific reference to vision impairment

- Psychosocial well-being
- Self-esteem
- Dance/Movement Therapy – definitions, origins, aims, types and structure
- Fusing the physical and psychosocial needs of learners with low vision with the goals of Dance/Movement Therapy.

Chapter 3: Research design

Chapter 3 provides in-depth details of the research design and methods, such as site and sample selection, data collection, data analysis, trustworthiness and ethical considerations.

Chapter 4: Empirical study – findings and discussions

Chapter 4 presents the results and discusses the findings of the empirical investigation in detail.

Chapter 5: Summation, conclusions and recommendations

In Chapter 5 a summary of the literature findings and the empirical investigation is presented in relation to the problem statement. This is followed by a conclusion, discussion of limitations of the current study and recommendations for further studies.

1.10 BENEFITS AND LIMITATIONS

Meekums (2002: 13) stresses the importance of further research in Dance/Movement Therapy – not only to promote this within the psychological and educational professions, but also to allow clients the privilege of being informed about this therapeutic option. It is also described as a fairly new and evolving field of therapy, which yields a variety of non- or under-researched topics, thus again underlining the need for such research.

Although this research endeavour is limited to a small number of participants, is context specific and thus cannot call for a generalisation of results, it may inspire further, more elaborate research with regard not only to Dance/Movement Therapy, but also to psychotherapeutic interventions which are made relevant for persons with sensory impairments. The researcher also hopes that this study may serve to increase awareness of this therapeutic intervention, which is still new to and underdeveloped within the South African context.

1.11 IN CONCLUSION

It is therefore the aim of this study to determine whether the holistic approach of Dance/Movement Therapy can equip six female adolescents with low vision with improved self-esteem and a consequent greater sense of psychosocial well-being, thus allowing them the opportunity to embrace the emotional cognisance of perseverance and triumph – to fly and not to crawl – as Helen Keller proposed (Keller in Guthrie, 2003: 75).

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

As set out in Chapter 1, the elements constituting this research study will now be investigated through existing literature in order to further clarify the concepts of impairment, low vision, psychosocial well-being as well as Dance/Movement Therapy, and how these aspects may be interrelated in creating the possibility of transcending somatic limitations.

2.2 DISABILITY AND / OR IMPAIRMENT ACCORDING TO PAST AND PRESENT THEORETICAL FRAMEWORKS

2.2.1 According to a medical model

Previously, the World Health Organization (WHO) used the International Classification of Impairments, Disabilities and Handicaps (ICIDH) to define disability within a medical model: impairment referred to a deficit in or defect of psychological, physiological and/or anatomical composition or operation, while disability referred to the limitations in capability of performing regular activities caused by the impairment. The challenges which such a person experienced within his or her social context were defined as handicaps (WHO, 1980: 4). Therefore, according to this model, a person's physical limitations are the central cause of all other difficulties which he or she may experience, and treatment or cure of the physical problem is the only likely solution (Imrie, 1997: 263).

2.2.2 According to a social model

In contrast to the medical model, a purely social perspective considers impairment as a communally constructed conundrum that is in principle politically motivated and consequently falls short in considering impairment as an individual trait by placing emphasis on the degree to which thoughts and feelings create unsupportive and unaccepting surroundings for persons with disabilities (WHO, 2002:9). Consequently, the WHO acknowledges impairment as a multifaceted portent that involves a relation between countenances of the individual as well as that of the person's circumstances and therefore calls for a perspective which assimilates both perspectives of the aforementioned models (WHO, 2002: 9).

2.2.3 According to a biopsychosocial model

In an attempt to move away from the parameters set by the ICIDH, the World Health Organization issued the International Classification of Functioning, Disability and Health (ICF) in 1980 to provide a more encompassing outline to depict health and conditions associated with health (WHO, 2002: 2). In contrast to the ICIDH, where disability commenced where health was halted in some manner or form, the ICF places the focus on salubrious performance, thus shifting the emphasis from disability to capability and therefore employing the ICF as a contrivance to determine an individual's operation within his or her social context irrespective of his or her physical deficiencies (WHO, 2002: 3).

The following quote elaborates on this fundamental alteration in thinking about impairment:

> "ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some disability. This is not something that happens to only a minority of humanity. ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience" (WHO, 2002: 3).

With this shift in emphasis, the WHO (2002: 4) concedes to the restricted legitimacy of both purely medical and social models which preceded the ICF and calls for an amalgamation of both as depicted in the following graphic presentation:

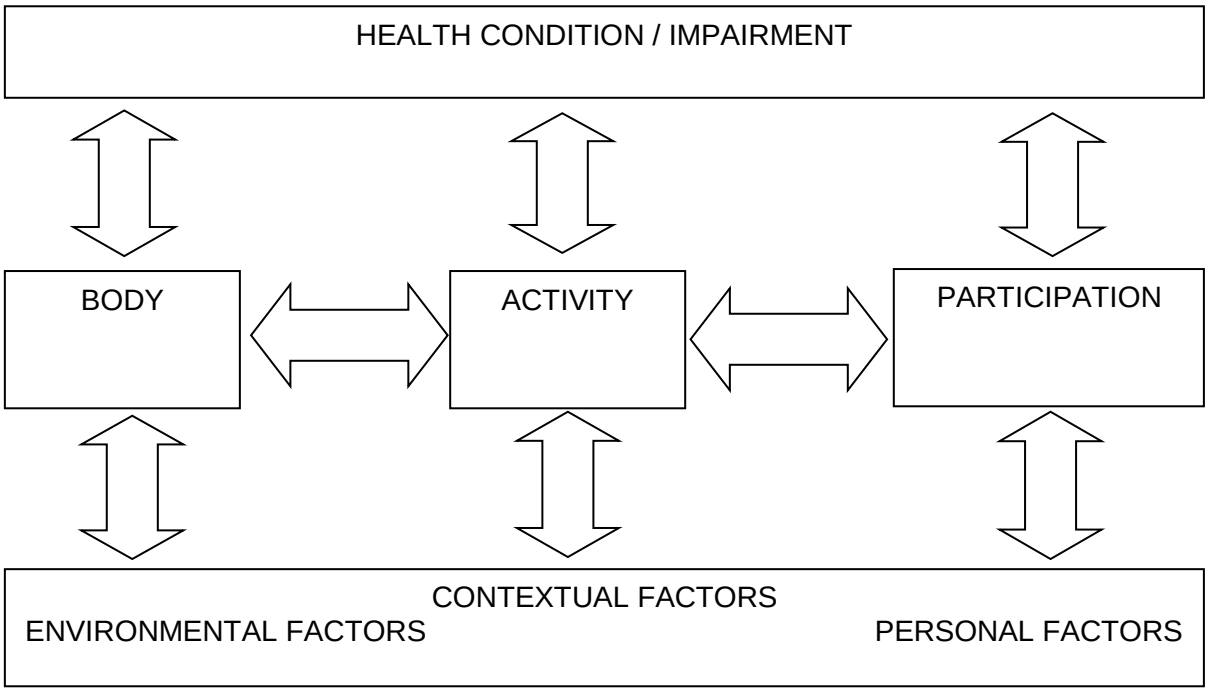


Figure 2.1 The relation between the human body, motion, involvement and impairment (WHO, 2002: 9) (Copied with permission.)

The above figure illustrates how impairment and participation in activity are interdependent and justifies why impairment cannot be viewed as simplistic but rather as multifaceted, implicating the physique as well as the surroundings in which it finds itself (WHO, 2002: 10). Therefore, as indicated in Figure 2.1, function or dysfunction results from a relation between one's physical state of well-being and circumstantial dynamics (WHO, 2002: 10). As depicted in Figure 2.1, these background elements are divided into individual and ecological elements (WHO, 2002: 9). Environmental dynamics include aspects such as public mindsets as well as licit and societal configurations, while personal features encompass considerations such as gender, age, coping mechanisms, social circumstances and schooling (WHO, 2002: 10). This suggests that anthropological operation happens on three planes: operation on an actual physical or bodily point, workings of the person as a holistic entity and also functioning of this all-inclusive unit within the social realm, which then implies that impairment occurs when there is dysfunction in one or more of these dimensions (WHO, 2002: 11).

To elaborate on this framework, the WHO published the International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) in 2007 as the substantial transformations in the corporeal, communal and emotional progression up until the age of 18 years were increasingly acknowledged and emphasised (WHO, 2007: vii). This version again professes the interaction between the physical, active participation and the contexts in which it occurs:

> "Thus, this derived version of the ICF for children and youth expands the coverage of the main ICF volume by providing specific content and additional detail to more fully cover the body functions and structures, activities and participation, and environments of particular relevance to infants, toddlers, children and adolescents" (WHO, 2007: viii).

This particular research endeavour has also referred to the significance of prospective dynamic engagement as well as the influence of limited opportunities for such participation in Chapter 1, section 1.4, thus further emphasising the mentioned interaction. Furthermore, it is this premise of interaction between the body, activity and participation, on which the idea of promoting active participation through a Dance/Movement Therapy intervention programme, in order to realise the transcendence of the participants' limited body structure due to low vision, is based. Finally, the fact that personal dynamics are included within the WHO's interactive framework suggests that individual responses to the contextual aspects with which these elements interrelate will differ based on the aforementioned factors such as

coping styles (WHO, 2002: 10). Adler (2009: 609) calls for an extension of the biopsychosocial model to include constructivism so as to account for the fact that no being will homogeneously respond to an incitement from the environment and which serves as the reason why this particular research endeavour has settled on working from a social constructivist approach.

Therefore, although the next section of the literature study will proceed to discuss medical aspects of impairment, this is mainly for clarification and elaborative purposes and does not mean that the researcher is following a medical model.

2.3 TYPES OF IMPAIRMENT

2.3.1 Physical impairment

According to Donald, Lazarus and Moolla (2014: 293), a physical impairment refers to a particular difficulty in the physical functioning of the body. In the case of visual impairment, it is the functioning of one of the senses, and specifically the loss of sight, that presents the problem. Consequently, visual impairment is further distinguished as a sensory impairment (Longmuir & Bar-Or, 2000: 49).

2.3.2 Sensory impairment

A sensory impairment refers to a deficit in or defect of any of the five senses, of which visual and hearing impairment are most common (Du Fue & Fergusson, 2003: 95).

2.3.3 Vision impairment

Vision impairment refers to a deficiency in terms of functionality of the ocular structure (Carvil, 2008: 470). It is further divided into two classifications based on the extent to which vision is compromised, namely low vision and blind (Meeus, 1994: 363; Naipal & Rampersad, 2018: 393). Should an individual still be able to read enlarged print, he/she would be diagnosed as having low vision, while a person who cannot read printed letters in any size or format and would therefore need the medium of Braille to read and write, would be considered blind (Mwamwenda, 2004: 337; Naipal & Rampersad, 2018: 394).

As can be deduced from the previous paragraph, an individual with vision impairment will have quite a unique series of developmental and educational needs which have to be provided for on an academic and social level in an adapted manner, while supporting and cultivating that person's individuality and ability as well (Donald et al., 2014: 321).

2.3.4 Low vision

Resnikoff et al. (2004: 845) explain low vision as visual acuity below that which is considered for normal functional eyesight (less than 6/18) but which is still more clear than that of a blind individual (equal to or better than 3/60). A person with low vision may also still experience 20% of field vision, while a blind person would only have 10% of field vision (Resnikoff et al., 2004: 846; Naipal & Rampersad, 2018: 394).

2.4 AN ELABORATION ON LOW VISION

2.4.1 Causes and prevalence of low vision

Causes of low vision include medical, genetic and environmental factors. Eye conditions, which are more often than not hereditary, can lead to a deficiency in eyesight. These conditions include nystagmus, retinal lesions, macular degeneration, glaucoma, diabetic retinopathy, trachoma, cataracts as well as retinitis pigmentosa. Injuries to the optical system can also decrease visual acuity and field perception (Gilbert & Ellwein, 2008: 879; Barstow, 2018: 3; Bakkar, Alzghoul & Haddad, 2018: 631). A survey conducted by the World Health Organization in 2002 indicates that 161 million individuals worldwide are classified as visually impaired. 124 million of these individuals were identified as having low vision (Resnikoff et al., 2004: 844).

However, according to Resnikoff et al. (2004: 845), Gilbert and Ellwein (2008:880) and Barstow (2018: 3), the prevalence of low vision is disproportionately distributed amongst population groups, as it is more common among females, more widespread in underdeveloped countries and more dominant in individuals above the age of 50. Eye conditions which are most prevalent amongst adolescents, which is the age group with which this particular research endeavour is concerned, mainly involve refractive errors. This implies a deformity of the eye shape which causes blurred vision due to light not being reflected accurately (Leat, Legge & Bullimore, 1999: 200). In terms of degenerative eye conditions which are prevalent amongst children and adolescents, Juvenile Macular Degeneration encompasses hereditary conditions which lead to central vision loss. This includes Stargardt's disease, Best disease and Juvenile Retinoschisis, for which there is no

curative treatment. Albinism, with co-morbid eye conditions such as nystagmus and homeopathy, is especially prevalent amongst adolescents of African heritage (Bakkar et al., 2018: 631; Resnikoff et al., 2004: 849).

2.4.2 Psychosocial impact of low vision

Morse (2004: 45) states that the extent to which low vision influences an individual's psychological and social welfare is as diverse as the low vision population is heterogeneous in terms of type and degree of vision loss, age, onset and socio-economic status. Sacks (2010: 67) agrees with Morse, stating that the emotional impact of living with low vision will differ due to age of onset, reactions and attitudes of important figures in the person's micro system, the degree to which the wider macro system is educated about and equipped for low vision, the severity and progression of vision loss as well as unique personal traits and capabilities of the person in question. Bakkar et al. (2018: 631) and Moses (2018: 421) concur with the above by explaining that low vision impresses on the diagnosed individual's bodily condition, emotional welfare and social interactions.

2.4.2.1 The person with low vision's macro system

According to Corn and Lusk (2010: 4) and also Goodrich and Heubner (2010: 35), the greater public is not educated in terms of low vision. This leads to visual behaviours and needs of individuals with low vision being misconstrued. Social isolation of the person with low vision then ensues as he/she feels misunderstood because of such misinterpretations (Sacks, 2010: 68). In fact, Sacks, Wolfe and Tierney (1998) determined that the degree of social isolation among adolescents with low vision is significantly elevated in comparison to blind and sighted adolescents for this very reason (Sacks, 2010: 75).

The degree of environmental access which a person with low vision experiences in his/her wider social system can further encourage or discourage acceptance and adaptation of his/her visual condition as it determines the level of independence when engaging in and with the outside world (Opie, 2018: 75; Sacks, 2010:68; George & Duquette, 2006: 3). Morse (2004: 44) is of the perception that such a sense of dependence or independence inadvertently then influences the person with low vision's identity and self-esteem.

Social interaction with and environmental feedback from the person with low vision's macro system also plays a role in self-esteem formation and the subsequent determination of psychosocial well-being, as individuals with low vision miss facial and postural nuances which sighted persons observe, process, interpret and then use to express their feelings and attitudes about themselves and towards others (Choi, Lee & Lee, 2018: 1; Morse, 2004: 49).

Hooper and Umansky (2009: 1) similarly explain the important role that vision plays in social exchanges through one's observation of others. Diamond (2002) is cited as stating that children with low vision experience challenges with social interactions as their limited sight inhibits them from observing and interpreting social cues, responses, social rules and conventions which inadvertently affects their self-esteem due to their uncertainty and fear of misconception (Hooper & Umansky, 2009: 2).

Finally, a lack of adult role models who are visually impaired could lead to feelings of shame and isolation which can severely hamper a child's self-confidence and subsequent self-esteem (Sacks, 2010: 81).

2.4.2.2 The person with low vision's micro system

According to Choi et al. (2018: 1), Opie (2018: 75), Sacks (2010:82), Morse (2004:45) and George and Duquette (2006: 6), family, peers and immediate professionals such as educators and specialists play a pertinent role in facilitating acceptance of and adaption to low vision. To do this, extensive comprehension of the psychosocial needs of a person with low vision is pertinent in order to endorse and reinforce the formation of a positive identity and subsequent self-esteem.

Sacks (2010: 79) elaborates on the above by specifically focusing on family customs and principles. Certain ethnicities might consider low vision to be a curse or punishment, causing the individual to be ostracised from the family, leading to further social isolation within the micro system as well. In other cultures, people might consider a person with low vision as a duty of repentance, causing them to do everything for that individual and making him/her dependant on their favour. In such cases, family members might also assume that the child with low vision is not capable of engaging in standard play activities, and siblings may not only become jealous of the excess attention shown to the brother or sister with low vision, but also experience frustration because he/she does not engage in such activities with them (Sacks, 2010: 74). More contemporary and/or informed families might however view the person with low vision as a proficient and valuable contributor to the household, thus contributing to a sense of independence and subsequent formation of positive self-esteem (Sacks, 2010: 75).

Morse (2004: 47) and Sacks (2010: 78) also emphasise the importance of the nature of encounters between a person with low vision and his/her peers in determining the degree to which he/she assimilates his/her physical condition with his/her emotional and social state. Again, the fact that the child with low vision does not clearly fall into the category of either

sighted or blind children, holds miscellaneous implications with regard to his/her abilities and prospects, causing the child to be perplexed about his/her identity, self-worth and group status (Morse, 2004: 48). Consequently, the phenomenon called “passing” sets in – especially during adolescence, when the child with low vision starts to notice discrepancies in the areas of dating, driving ability, physical appearance etc. In an effort to be assimilated as one of the group, he/she refrains from using assistive devices or any other resource which might make him/her stand out (Sacks, 2010:74). The low vision adolescent therefore attempts to come across as fully sighted in order to gain a sense of belonging. However, more often than not, this leads to emotional and social strain because the individual with low vision does not receive the optical information which his/her peers receive (Sacks, 2010: 75).

2.4.2.3 The self of a person with low vision

According to Burmedi, Becker, Heyl, Wahl and Himmelsbach (2002: 47), individuals with loss of vision need to make a range of emotional and social adjustments. The feedback these individuals receive from their micro and macro systems also impacts on the degree to which they are able to make such psychosocial amendments (Keefe, 2005: 167). For example, Sacks (2010: 77) found that the manner in which family, peers and involved professionals communicate information about the person with low vision’s impairment determines the degree to which he/she is able to convey details about him/herself.

Sacks (2010) furthermore explains that individuals with low vision – especially adolescents – experience anxiety as they deal with the trepidation about future vision loss. This, along with the challenge of managing the stressors of the sighted world as well as a possible perception of dependence and loss of control, as discussed in previous paragraphs, could lead to depression (Sacks, 2010: 78). As an illustration of this, Moses (2018: 420), states that alarmingly elevated numbers of suicide attempts have been reported amongst adolescents with visual challenges, along with their hearing impaired and autistic spectrum diagnosed counterparts, as these groups are excessively exposed to hazardous dynamics that are predictive of suicidal conduct.

The fact that research into daily activities of individuals with low vision has indicated that they spend the majority of their available time engaging in passive activities such as watching television, listening to the radio or sleeping up to 12 hours per day, does not alleviate the possibility of being diagnosed with depressive symptoms (Barstow, 2018: 4; Choi et al., 2018: 1; Sacks, 2010: 80; Keefe, 2005: 170; Burmedi et al., 2002: 49). This is even more comprehensible when considering the psychosocial benefits which physical activity presents, as was discussed in Chapter 1, section 1.3.2.

Sacks (2010: 81) and Wahl, Schilling, Oswald and Heyl (1999: 304) have all found that persons with low vision view themselves more negatively than do their blind counterparts. Morse (2004) elaborates on this by citing Bateman (1962) as stating that children with low vision pity themselves more and are less able to accept and transcend their impairment than their more severely impaired counterparts who are blind (Morse, 2004: 48).

All of the above-mentioned authors attribute this negative perception to identity formation. In fact, in the foreword of their book *Foundations of Low vision*, Corn and Erin (2010) cite Kekelis and Sacks (1992) and Maccupsie (1996) as having identified a number of children who experience challenges in relating their opinion about their identity to others. According to Sacks (2010:85), this negative perception of self is also linked to the individual with low vision's perception of his/her own physical appearance. Morse (2004: 46) attributes this to a negative body image which stems from limited engagement in physical activity.

According to Morse (2004: 46), the fact that low vision individuals do not have accurate visual feedback regarding the functioning of their bodies, and that they receive conflicting environmental feedback when comparing themselves to the greater sighted population, has a significant impact on their self-esteem. Furthermore, the fact that their degree of vision can fluctuate, deteriorate and in some instances improve, also leads to fluctuations in self-esteem (Morse, 2004: 47).

Sacks (2010: 69) also writes about the "neither fish nor fowl" phenomenon, which refers to the fact that the terms "sighted" and "blind" provide clear defining elements for creating two stereotypical categories which imply certain normative guidelines of conduct, while the function and status of the individual with low vision is more ambiguous due to the heterogeneous nature of the condition. Morse (2004: 47) agrees with the above, explaining that individuals with low vision are not classified as sighted nor blind, which further influences self-perception and subsequent self-esteem. This in turn makes it more difficult for them to adjust to and accept their visual limitations – in other words to transcend their sensory impairment.

2.5 TRANSCENDENCE

Mesulam (2002:8) defines transcendence as the psychological ability to ascend above (in other words to overcome) concrete difficulties presented by the human body and the environment in which it finds itself. Kolcaba (2003: 75) describes transcendence as the

motivation, determination and strength to overcome challenges. Delgado and Humm-Delgado define it as a sense of enabling empowerment (Delgado & Humm-Delgado, 2017: 106; McCarthy, Hall, Crawford & Connelly, 2017: 854).

Kidd (2010: 10) writes that the concept of transcendence relates back to the theoretical conceptualisations of Adler (1979) and Frankl (1969). Frankl's Existential Theory describes self-transcendence as a superior field of cognisance characterised by determination, endurance, self-engagement and hope. He believed that humans possess the ability to rise above disabling aspects presented by external factors such as one's environment or body (Kidd, 2010: 11). Wong (2014) also refers to the core of Frankl's logotherapy as guiding an individual to identify and accept his/her duty to contribute and ascribe distinct meaning to his/her existence when he calls for a shift from the physical to the spiritual to bring about healing and well-being. Contemporary psychologists refer to this acknowledgment of responsibility for the self and subsequent awareness of self in the present as a state of mindfulness (Marques-Brocksopp, 2014: 108). Adler's Individual Psychology also places emphasis on human qualities such as selflessness, resourcefulness and individuality and that such characteristics can "make man the master of his fate as opposed to a victim of circumstance" (Kidd, 2010:12). This statement in itself, suggests the ability of transcendence.

Mesulam (2002) explains that the cognitive ability of transcendence is localised in the brain's frontal lobes. In his writings, he retells of Phineas Gage, a 25 year old foreman at a railway construction site who was severely injured during an explosion, but was still able to explain what happened in detail, not appearing to be in any significant distress (Mesulam, 2002: 9). At that moment, Phineas Gage was able to transcend his physical pain to give information which was critical to the rescue endeavour. Marques-Brocksopp (2014: 123) has found that such mindfulness through increased intra- and interpersonal connection leads to a greater sense of self-perceived emotional, social and physical health among individuals with low vision, thus suggesting that they are able to transcend their sensory impairment.

2.5.1 Transcendence of vision impairment

Corn and Erin (2010) consider the person with low vision's ability to transcend above his/her sensory impairment as being linked to the following determinants: the person's degree of functionality, the availability of assistive resources, the extent of social support, the effectiveness of his/her coping strategies and the individual's own disposition.

Morse (2004: 50) in turn considers low vision individuals' ability to assimilate their degree of vision positively with their self-esteem and social interaction as successful adjustment to their sensory challenges and cites Bishop (1972) as saying that positive self-concept, self-acceptance and self-expression are contributing factors to an improvement in self-esteem. Furthermore he also cites Allen (1972), who considers positive interrelations with the rest of the environment as key to developing constructive self-esteem (Morse, 2004: 51).

From sections 2.4 and 2.5 it is clear that the physical condition of low vision interplays with the individual's psychological and social state. Therefore, the meaning of well-being, and more specifically psychosocial well-being, will now be discussed.

2.6 PSYCHOSOCIAL WELL-BEING

Blustein (2008: 228) describes well-being as a state of overall health and contentment, while Diener and Chan (2011: 1) view well-being as a subjective sense of life satisfaction. Bradburn (1969: 2) considers an individual's well-being to be a holistic concept as a person's physical and psychological health are not only interdependent on each other, but are also influenced by an equally inter-reliant society. Tickerhoof George (2005: 8) refers to Learner's Developmental Contextualism (1987) and the constructs of "embeddedness" and "dynamic interaction" to explain the reciprocal relationship between biological, psychological and social experiences which determine a person's state of being – thus the concept of psychosocial well-being.

2.6.1 Psychosocial well-being and self-esteem

According to Neff (2011: 2), a determinant construct of one's psychosocial well-being is self-esteem. It is the evaluative structure of one's personality which determines the sense of worthiness and value (Neff, 2011: 3). Neff (2011: 4) cites the sociologist Charles Horton Cooley (1902), to explain that levels of self-esteem are not solely determined by an individual's own perception of competence but also by 'the looking-glass self' – how one perceives oneself through the eyes of others. Papadopoulos, Montgomery and Chronopoulou (2013: 4565) also view self-esteem as stemming from interactions between an individual and significant role players in the person's life.

Dogan, Totan and Sapmaz (2013: 31) write about the pertinent role which one's perception of self-efficacy and subsequent self-esteem plays in an individual's psychosocial well-being. As mentioned in Chapter 1, section 1.3.2, Paradise and Kermis (2002: 345) determine that

higher self-esteem is connected to a greater sense of psychosocial well-being as autonomy, environmental mastery and a sense of purpose are contributing factors to the former.

To return to individuals with low vision, the fact that independence, sufficiency and control are linked to the person's sensory impairment, suggests that their physical condition will inadvertently affect their self-esteem and subsequently, their psychosocial well-being (Ishtiaq, Chaudhary, Rana & Jamil, 2016: 432). Schinazi (2007) explains how a person with low vision's level of psychosocial adjustment influences his/her self-esteem and vice versa. Loss of vision is more often than not associated with lower levels of self-esteem (Papadopoulos et al., 2013: 4565). Tuttle and Tuttle (2004: 25) attribute this to ambiguous behaviour (not the behaviour of a typically sighted or blind person) which leads to embarrassing and/or conflict situations, making self-acceptance and subsequent self-esteem and improved psychosocial well-being more difficult.

However, Tuttle and Tuttle (2004: 7) write that low self-esteem and psychosocial well-being do not have to be the norm for individuals with low vision and refer to various case studies where challenges in these areas were successfully resolved with the necessary understanding, support and input. Crandell and Robinson (2007: 98 - 145) hold a similar conviction and consider change in perception, emotion, attitude, motivation and mobility as key factors to guide people with low vision to overcome their sensory impairment.
Scheiman, Scheiman and Whittaker (2007: 88) also write about how improved psychosocial well-being through a boost in self-esteem can assist occupational therapists in the process of physical rehabilitation of persons with low vision. Morse (2004: 50) suggests that a person with low vision is capable of transcendence if he/she can successfully incorporate his/her impairment with his/her self-esteem and subsequent social interactions. He believes that focusing on the individual's self-concept, self-acceptance, self-expression and inter-relations will improve overall self-esteem and psychosocial well-being.

What the above-mentioned authors are suggesting is that the individual with low vision's potential to rise above his/her sensory limitations – in other words to transcend their condition of low vision and successfully adapt to its challenges – lies in the improvement of their psychosocial well-being.

To conclude on this section, Sacks (2010: 93) pleads for the following:

> "Although curricular materials that include emphasis on psychological and social aspects of low vision have been developed by Corn & Rosenblum, 2000 and Corn, Bina & Sacks, 2009, professionals need to continue to develop other

> materials and programmes to enhance the psychosocial adjustment of children and adults with low vision."

Thus, it is clear from the studied literature that the sensory condition of low vision does affect a person's psychosocial well-being, but that such individuals also have the ability to transcend such limitations through positive self-esteem and social support. This emphasises not only the need for but also the feasibility of a psychosocial intervention and it is the aim of this research endeavour to determine whether a Dance/Movement Therapy intervention programme can provide learners with low vision with an opportunity to enhance self-esteem and improve psychosocial well-being so as to transcend their sensory limitation.

2.7 DANCE/MOVEMENT THERAPY (DMT)

Farrel (2006: 76) suggests that the premise made in the previous section of Dance/Movement Therapy being applied as an intervention programme to enable psychosocial adjustment, is indeed possible. To support his statement, he refers to the Association for Dance Movement Therapy UK, which has held various workshops, conferences and seminars as well as released numerous publications on working with children with sensory impairments.

In further support of this, Farrell (2009: 90) also cites Payne (2006) as stating that Dance/Movement Therapy can be applied in an extensive range of settings, ranging from adults with dementia to children with various forms and levels of impairment. He goes on to explain how Dance/Movement Therapy not only allows for the expression and release of emotions, but also improves physical abilities, which in turn boosts self-confidence and self-esteem – thus again establishing that Dance/Movement Therapy indeed holds a psychosocial approach to therapy. He specifically refers to the benefits for children with sensory and/or orthopaedic impairments, as Dance/Movement Therapy can not only improve these children's body image, but can also enhance their self-esteem and social representation (Farrell, 2009: 91). LeFeber (2013: 125) echoes the psychosocial nature of Dance/Movement Therapy by citing the American Dance Therapy Association's definition of Dance/Movement Therapy, which focuses on the integrated nature of this approach as the therapeutic aim thereof is to enhance the physical, cognitive, emotional and social assimilation of the person.

Furthermore, she and other authors also refer to the fact that it has been proven to be an effective mode of intervention for individuals with medical, social, psychological and physical impairments (LeFeber, 2013: 136; LeFeber, 2014: 463; Goodill, 2005: 87; Meekums, 2002: 4; Levy, 1988: 50). In more recent studies, Dance/Movement Therapy has, for example, been employed to screen and therapeutically treat individuals with opioid addiction, improve the psychological and social welfare of schizophrenia patients, and to assist patients with Post Traumatic Stress Disorder (Kirane, 2018: 13; Bryl, 2018: 315; Parker, 2018: 100).

The application of dance/movement as a psychotherapeutic and curative instrument is founded on the conception that the physical and the psychological are inextricable as the body's movement mirrors the intrapsychic condition. This then further implies that conversions of motor activities can establish emotional and cognitive transformations and in so doing advance development and well-being (Levy, 1988: 17). "Academically, the field combines and synthesizes the study of psychological and social processes with other theoretical constructs from both the art of movement and kinesiological/biological principles of movement" (Goodill, 2005: 16). Payne (2006: 3) states that the growth and health as mentioned by Levy (1988: 17) are more often than not associated with creativity and that the ability of these respective features exists within each human being. Therefore, it is implied that movement and its traits of improvisation and re-enactment – specifically that of previous occurrences – can assist in relieving strain as well as promoting self-expression and assimilation (Payne, 2006: 2).

Resonating with the concerns regarding inactivity as mentioned in Chapter 1, section 1.4, Payne (2006: 2) also expresses her trepidation about modern society's declining regard for physical activity and the subsequent repression of energy, which inadvertently leads to tension and even depression. The fact that movement through dance is physical, active, expressive and communicative means that pent up adrenalin and ensuing aggression, rigour and indifference can be released in a communally appropriate way (Payne, 2006: 3). "To dance out anger or joy, love or sadness enhances the individual's ability to express these affects. Inaction and depression are often synonymous; the creative act of moving alone or with others can enable an integration of mind, body and spirit" (Payne, 2006: 3).

2.7.1 An elaboration on Dance/Movement Therapy

Devereaux (2014: 85) refers to Dance/Movement Therapy as a "body-based intervention". Dance/Movement Therapy can be explained as a mode of self-articulation and communication through the physical, rhythmic transference of the body in order to promote the beneficial assimilation of the body and mind. It employs the interrelationships of

movement components, such as energy, pace, flow and space to acquire an understanding of an individual's personality as well as to create a channel for expression and an opportunity for socialisation (Chaplow-Lindner, Harpaz & Samberg, 1979:37).

As dance is more widely considered as an art form than a therapeutic medium, it is important to distinguish between the former and the latter. While movement and its elements of body, time, space and energy is the means through which both artistic and therapeutic means are accomplished, the assumptions, context and goals differ considerably (Goodill, 2005: 16). Although Delgado and Humm-Delgado (2017: 106) aver that dance as a performing art in itself already inspires adolescents with impairments, when taking personal progress and welfare into account, dance as a performance art is more focused on exercise, education and/or professional performance, while dance and movement within a therapeutic setting will not be concerned with aesthetics but will rather be centred around its psychological and social nature (Meekums, 2002: 4). Therefore, the main discrepancy is situated within the fundamental philosophy of Dance/Movement Therapy: the conviction that there is a relation between motion and emotion. Consequently, the focus is on guiding the mover to delve into the connection within the context of his/her personal life encounters in order to restore and/or enhance the affiliation between the physical and the psychological (Payne, 2006: 7).

According to Tortora (2006), dance and movement can be used as a form of assessment as well as an intervention, as she does not only consider the non-verbal cues of an individual's movement as indicative of his/her physical, emotional, social and cognitive development, but also believes that using that very same movement can expand physical abilities and strengthen the person emotionally and socially by engaging him/her in movement and music (Tortora, 2006: 61). LeFeber (2013: 126) also writes that Dance/Movement Therapy is both a mode of assessment as well as one of treatment. Recent developments in the field of Dance/Movement Therapy include the employment of the technological application called MARA (Movement Assessment and Reporting App) which not only enhances therapeutic outcome-based assessment, but allows for assessment feedback to be utilised as part of the treatment process as patients can reflect on their progress on a digital plane (Dunphy & Hens, 2018: 2).

This chief objective of Dance/Movement Therapy is encapsulated by Levy (1988: 50) as being assistive in nature: to help individuals who are in general good health, persons who experience emotional or mental difficulties or who are physically impaired, to reclaim a sense of holisticity by working with the body, mind and spirit collectively.

2.7.2 The origin and pioneers of Dance/Movement Therapy

The origin of Dance/Movement Therapy stretches back to Carl Jung (1916) and Sigmund Freud (1923) who both displayed an interest in, and later on recognition of, the association between the body and the psyche (Chodorow, 1999: 228). While Freud recognised that non-verbal behaviour could be a valuable tool in psychoanalysis, Jung observed and studied his patients' unconscious motor behaviour as symptomatic, expressive and indicative actions. He also advocated the theory of the active imagination, which gave relevance to therapeutic modes that were based on creative expression (Chodorow, 1999: 229).

Dance or movement has however been used for healing purposes since primitive times, which suggests that the concept of a mind-body-spirit interrelation has been grasped for hundreds of years (Hanna, 1990). Dance rituals were also used to recognise life events, thus intimately integrating individuals with their life status, as well as with their communities (Hanna, 1990; Payne, 2006). Due to these emotional, physical, spiritual and communal components, movement is considered to be naturally therapeutic, necessary and effective (Chaiklin & Wengrower, 2009: 28).

Modern Western civilisation had however lost sight of these aspects of movement as it embraced dualism, which emphasised the separation of mind and body (Levy, 1988: 10). Classical dance in the 19th and 20th centuries consequently paid little or no attention to the emotional response of the dancers themselves, thus missing the therapeutic potential of movement in general (Goodill, 2005: 8). During the 1940s, modern dancers began to recognise the emotional and mental benefits of creative movement and introduced the concept of movement to the mental health profession (Payne, 2006: 7). Therefore, Dance/Movement Therapy finds its origins with modern dance pioneers like Isadora Duncan, Martha Graham and Doris Humphrey. They transformed dance from stylised forms like ballet into a self-expressive, spontaneous form, where individuality was encouraged (Levy, 1988: 17; Goodill, 2005: 8; Payne, 2006: 3).

The work of Marion Chace (1940) with the non-verbal population made her a pioneering Dance/Movement therapist, who considered movement a valid therapeutic modality based on it being a universal means of communication. Subsequently, she theorised that due to its communicative nature, movement addressed a basic human need (Cleary, 2002: 43).

During the 1950s Mary Whitehouse designed a methodology which she described as "movement in depth" (Cleary, 2002). This comprised the following five aspects:

- kinaesthetic awareness, which refers to an awareness of one's physical self and a more intimate knowledge of bodily movement;
- polarity, that embraces the concept of opposing drives and promotes the recognition and expression thereof;
- active imagination, as a means of accessing, expressing and controlling the unconscious self;
- authentic movement, which promotes and stimulates the active imagination by breaking free of the controlled ego-state; and
- therapeutic relationship, referring to the intuitional trust between the therapist and the client (Cleary, 2002:48).

During the same era, Blanche Evan was concerned with the suppressive and adaptive behaviour of the modern, urbanised child and adult, and their loss of contact with their bodies and emotions (Levi, 1988: 33). She dedicated her work in Dance/Movement Therapy to treating this neurosis by allowing the expression of what seems like the inexpressible through movement and metaphor (Levy, 1988: 34). Evan particularly made use of projective techniques such as sensitisation as a preparatory method to lead potential movement into actual movement through the stimulation of dance components such as rhythm, space, flow and content. This was achieved by offering distinctive images, stimuli and movement ordinances (Levy, 1988:43).

In the 1960s, Liljan Espenak contributed to the field by integrating the Adlerian hypotheses concerning the aggression drive, feelings of inferiority and social feelings into her theoretical concept of Dance/Movement Therapy, and by showing how the development of bodily strength and the establishment of expressive movement vocabulary can serve to thwart such initial feelings of inadequacy and reliance (Levy, 1988: 54). Espenak also created a series of Movement Diagnostic Tests to assess possible positive and negative constituents of a person's personality, including that of ego-strength, self-assertion, resilience, sense of reality, emotional changes and control thereof as well as risk-taking (Levy, 1988: 57).

Alma Hawkins worked with polarities of energy, space and time during the 1970s and focused on the manner in which such extremes influence an individual's range of movement and subsequent expression which inadvertently affect his or her experience and consequent perception (Payne, 2006: 5). This led Hawkins to place an emphasis on relaxation as part of Dance/Movement Therapy in an attempt to identify and constrain tension, relegate apprehension as well as inevitably expand movement and in so doing promote perception (Levy, 1988: 92).

It was Rudolf Laban and his protégé Warren Lamb however who provided techniques for analysing movement, and procedures for documenting such analysis in the fairly new profession of Dance/Movement Therapy, by creating a vernacular which was distinctive from other disciplines and therefore establishing this developing field (Cleary, 2002: 45).
Laban stressed the intricacy of human movement in its capability of reflecting not only conscious but also unconscious thoughts, emotions and contradictions, as well as in its capacity to impart customs, habits, rituals and means of coping (Levy, 1988: 132; Cleary, 2002: 46). It is especially the last mentioned which Laban believed to be expressed through what he called movement configurations. He also highlighted the person's proficiency to transform such patterns (Levy, 1988: 133). Laban's movement framework, which focuses on physical form, placement, industry and connection, is still being applied today to guide children in learning movement through physical education (Langton, 2007: 17).

According to Levy (1988), Joanne Weisbrod (1974) pioneered the practice of Dance/Movement Therapy with the visually impaired after she noticed the cautious and constrained demeanour of interchange as experienced by an individual who is hesitant to move without the guidance and assurance of sight. Weisbrod thereafter underlined the necessity of creating a secure space within which to conduct Dance/Movement Therapy as it could encourage the use of the body as a whole and thus promote comprehensive interaction (Levy, 1988: 133; Cleary, 2002: 50). Through this she aimed to guide the visually impaired to completely own, employ, appreciate and enjoy their bodies through proliferated perception and understanding of their strengths, weaknesses and ability in movement, enhanced body image and gross motor skills, positive reinforcement of current movement abilities and a gradual increase in their range of movement. She believed that these goals could be accomplished through the creation of multi-sensory experiences (Levy, 1988:239).

2.7.3 The theoretical framework of Dance/Movement Therapy

The fact that Dance/Movement Therapy can be considered as a psychosocial intervention is again confirmed when considering the various theories upon which this approach has been based.

Keeping the aforementioned dimensions of movement in mind, it is easy to understand why Dance/Movement Therapy is based on the biopsychosocial model as proposed by Engel in 1977 (as cited by Goodill, 2005: 19). This approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery (Goodill, 2005: 19). Furthermore, when considering the

communal aspects of movement and dance, together with the biopsychosocial model, Von Bertalanffy's Systems Theory (1968) also serves as a theoretical foundation for this therapeutic approach, as a system can be described as multifaceted aspects that form part of a structured and interactive process (Laszlo & Krippner, 1998: 64). This again suggests that individuals cannot be comprehended as isolated entities, but rather as a part of a larger whole – a cohesive system; a multigenerational unit – which in itself is embedded in a community and in society at large (Laszlo & Krippner, 1998: 65).

Recent trends in psychological literature are also combining concepts from developmental sciences and psychoanalysis to formulate the Embodiment Theory. The Embodiment Theory entails an encompassing explanation of human development by incorporating the complex systems that are the mind and the body (Connet, 2011: 40). Developmental science proposes that the individual is considered to be an active, intentional agent of an integrated, complex, dynamic and adaptive person-environment system, and that his/her development takes place within this context. Consequently, Piaget's developmental theory about how perception is derived from the body has been incorporated into the Embodiment Theory (Connet, 2011: 26). Embodiment therefore refers to bodily expressions towards, as well as movement and interaction with, the environment which are determinant of one's perception, cognition, affect, attitudes, behaviour, and the interrelations between these (Connet, 2011: 46).

In keeping with the mentioned theoretical frameworks, Dance/Movement Therapy is based on the following guiding principles (LeFeber, 2013: 127; Meekums, 2002: 13):

- Behaviour is a means of communication.
- Movement reflects personality.
- Changes in movement will eventually lead to modification of the personality.
- An extensive movement vocabulary allows for a greater ability to engage with the environment.

Keeping the above in mind, LeFeber (2014: 464) refers to four classifications which constitute the framework for Dance/Movement Therapy:

- Body Action, which refers to the intense physical movement of an individual's body with the aim of increasing bodily consciousness in terms of space and physical impression in different parts of the body.
- Symbolism, which is the person's employment of enactment, imagery, fantasy and recollection to allow the conceptualisation and construction of acceptance.

- The therapeutic movement relationship which encourages trust and subsequent open communication between the client and therapist through a compassionate, compliant and dependable setting.
- Rhythmic Group Activity, which is the application of rhythm to alter radical behaviour, normalise feelings, enhance group unity and facilitate constructive emotional and cognitive exchanges amongst group members.

2.7.4 Types of Dance/Movement Therapy

Due to the variety of pioneers and various theoretical perspectives from which each individual worked, there are different approaches to Dance/Movement Therapy, which has resulted in various categories of this form of art therapy. Some approaches emphasise sensory awareness, while other perspectives apply movement as a form of psychotherapy, expressing and addressing deep emotional issues. Certain approaches emphasise aligned, structured and specific movement sequences, while others embrace spontaneous movement. Then there are also approaches which focus primarily on improving the ease and efficiency with which one's body moves (Payne, 2006: 16).

Briefly mentioned in the previous section, the Laban Movement Analysis (LMA) is a comprehensive system for discriminating, describing, analysing, and categorising movements, which can be applied to dance, athletic coaching, fitness, acting, psychotherapy, and a variety of other fields (Levi, 1988: 22; Cleary 2002: 50; Langton, 2007:17). It allows movement to be analysed through observing recurring patterns, noting movement preferences, assessing physical blocks and dysfunctional movement patterns, and then suggesting and implementing new movement patterns (Movement Therapy Foundation, 2012).

Authentic movement (AM) is based upon Mary Starks Whitehouse's understanding of dance, movement, and depth psychology. There is no movement instruction, but a mover and a witness are required (Levi, 1988: 25). Movement is initiated internally by the mover and then spontaneously flows as a reaction to this impulse. The movements may be in response to an emotion, a dream, a thought, pain, joy, or whatever the mover is currently experiencing. At the end of the session the mover and the witness reflect on their experiences (Cleary, 2002: 51). Lavendel (2016: 211) advocates for this particular approach to Dance/Movement Therapy by emphasising the holistic nature of Authentic Movement as its very nature presents the possibility of biopsychosocial development.

The Mensendieck System of Functional Movement Techniques is both corrective and preventative in nature and is designed to reshape, rebuild and revitalise the body. It educates the client to use the conscious will to relax muscles in order to release tension. There are more than 200 sequences that emphasise correct and graceful body movement through everyday activities (Movement Therapy Foundation, 2012).

Body and Mind Centring (BMC) is a comprehensive educational and therapeutic approach to movement. Movement, touch, guided imagery, developmental repatterning, dialogue, music and props are employed to meet the needs of each individual client. BMC facilitates clients to develop an awareness and experience of the ligaments, nerves, muscles, skin, fluids, organs, glands, fat, and fascia that constitute one's body. It has been effective in preventing and rehabilitating chronic injuries and in improving neuromuscular response in children with cerebral palsy and other neurological disorders (Movement Therapy Foundation, 2012).

The movement form of Trager's psychophysical integration bodywork, Mentastics, consists of fun and easy swinging, shaking, and stretching movements. These movements serve to create an experience of lightness and freedom in the body, allowing for greater ease of movement and have proven especially successful in the treatment of polio patients (Levi, 1988: 30; Cleary, 2002: 55).

Eastern movement therapies such as Yoga and T'ai Chi are also effective in healing and preventing a wide range of physical disorders, encouraging emotional stability, and enhancing spiritual awareness (Cleary, 2002: 57).

2.7.5 The general structure of a Dance/Movement Therapy session

In general, a Dance/Movement Therapy (DMT) session will comprise the following components, each of which allows for unique expression and processing, while still contributing to a unified session with interrelated therapeutic outcomes (LeFeber, 2013: 130):

- It will commence with an introductory warm-up phase which prepares the client for more intense movement, and simultaneously serves to release any tension or constriction in the body which might inhibit the recognition of emotional material (Payne, 2008: 34). LeFeber (2014: 465) cites Adler (2003), by stating that this component does not only initialise contact between the client and the therapist and pioneer awareness of bodily sensations for the client, but also presents the opportunity for the therapist to assess the client's current state of being, which then serves to inform the next component of the Dance/Movement Therapy session.

- It then progresses to a phase of deeper exploration of themes which might be expressed spontaneously, or through the facilitation of the therapist (Payne, 2008: 34). According to LeFeber (2014: 466), who cites Chaiklin and Schmais (1993), it is at this point in the session where "learning and processing" occurs on a more profound level as movement which was initially concrete in meaning becomes more symbolic under the guidance of the facilitator or therapist.
- It then ends with a cool-down section, which serves to fuse the emotional and physical material for the client, preparing the client for the closure of the session and re-entry to the present (Payne, 2008: 34). Reflection on what was experienced during the session, identifying skills which were acquired, and grounding the client through a point of closure is essential during this component in order to ensure the cohesiveness and thus the effectiveness of the session as a whole (LeFeber, 2014: 466).

LeFeber (2013: 134) suggests that the structure should remain flexible and universal so as to accommodate the explicit needs of each client. In doing so it allows for the necessary sense of security, but also fosters unlimited creativity and uninhibited expression (Payne, 2008: 35; LeFeber, 2013: 135).

2.7.6 Music as an element of a Dance/Movement Therapy session

Koch, Morlinghaus and Fuchs (2007: 340) engaged in a study with three groups: a dance group, a group that listened to the dance music and a group who rode training bicycles until they reached the same level of exertion as the first group. Although all three groups experienced positive results, the first group, which combined movement and music, indicated an alleviation in symptoms of depression. Payne (2008: 3) suggests that the results of Dance/Movement Therapy can be enhanced by using props, music, rhythm etc. The feasibility and advantage of this, as initially proposed by Weisbrod (1974), is supported below:

Sandel and Kelleher (2012) view music as stimulating the commencement of a Dance/Movement Therapy session because it speaks to the body's instinctive proclivity to respond to rhythm. Vocalisation initiates breathing, which enhances central body involvement and subsequent body awareness. Props motivate activity and interaction as well as sensory stimulation, amplifying intra- and interpersonal awareness (Sandel & Kelleher, 2012: 30). Sandel and Kelleher (2012: 29) also emphasise the importance of using props and music, which engage alternative senses, when working with individuals who have physical and/or sensory impairments.

Bertolami and Martino (2002: 2) cite Nordorf and Robbins (1977) in stating that children with visual impairment have an inherent predisposition to musicality. Studies done by Pring, Woolf and Tadic (2008: 290) on children suffering from congenital blindness, and Ockleford and Matawa (2010: 163) on learners diagnosed with retinopathy, suggest a similar inclination among their research participants.

This led the researcher to compare the goals of Music Therapy and physical activity (as discussed in Chapter 1, section 1.4), as both music and active movement are elements of Dance/Movement Therapy (Pratt, 2004: 827). Literature suggests various parallels in outcomes, including change in areas of attention, concentration, impulse control, social functioning, self-esteem, self-expression, motivation, and cognition (Pelliterri, 2000: 381).

The researcher therefore surmised that there is rationale to be found in combining music and physical activity in the form of a Dance/Movement Therapy programme so as to create not only the previously mentioned prospects for increased physical activity, but also to attempt to improve the psychosocial well-being, specifically the self-esteem and social functioning, of learners with low vision. When the researcher further took the learners' cultural background into account, considering that South Africa is rich in music and dance, Dance/Movement Therapy seemed an even more viable intervention as the importance of anthropological background in the application of any therapeutic technique was also emphasised in the researcher's review of related literature (Hanna, 1990: 115). Furthermore, the fact that Morse (2004: 51) suggests that it is pertinent for interventions to aim to obtain, interpret and express information from the environment, made the inclusion of music in a Dance/Movement Therapy intervention programme seem even more feasible.

2.7.7 Amalgamating the physical and psychosocial needs of learners with low vision and the goals of Dance/Movement Therapy

LeFeber (2013: 126) surmises that the aim of Dance/Movement Therapy will be to produce a structured environment which cultivates enough security to liberate inhibition. Where, through kinaesthetic empathy, the client feels comprehended on a physical level, with a sense of belonging fostered through mutual contact and communication between the client and the therapist.

Based on the above, Dance/Movement Therapy has the following goals in mind:

- It aims to foster a physically and emotionally safe, non-judgmental environment that is respectful of individual limitations and achievements and to facilitate individual expression and communication with other people (Carvil, 2008: 467).
- It also proposes to increase body awareness, spontaneity, creativity and a healthy self-esteem and to promote and integrate emotional stability – including anger management and stress reduction (Levi, 1988: 50; Payne, 2006: 31; Carvil, 2008: 468).
- Finally, it sets out to support personal growth through insight, energy, and an expanded movement repertoire (Koch, Morlinghaus & Fuchs, 2007: 344).

LeFeber (2014: 464) cites the work of Lily Thom (2010) which focused on the employment of Dance/Movement Therapy to promote psychosocial development by fostering an association between one's physical experience and cognisant evaluation of emotions which in turn enhance one's self-esteem. Through heightened self-esteem, the person is better able to deal with emotional, social and physical trials (Carvil, 2008: 468). Movement metaphor, imagery, associations and symbolisation are used to link emotional and physical processes (Duquette, 2010: 6; Nolan & Goodill, 2015: 158). The use of imagery and movement metaphors is what differentiates Dance/Movement Therapy from other body-based therapies by lending a symbolic, mutual meaning to a basic physical action (Sandel & Kelleher, 2012: 29). Kinaesthetic empathy can intervene in and impact on experience in encounters with others and the environment (Reynolds & Reason, 2012: 20; Duquette, 2010: 7). Empathetic movement, according to Sandel and Kelleher (2012: 27), serves as a fundamental precursor for group interaction. Brehm and McNett (2007: 37) also stress the kinaesthetic link between movement, cognition and feeling.

Moore (2012), who specialises in Movement Pattern Analysis, believes that movement is a metaphor for individual experiences, as mirror neurons communicate that which is felt to the body's movement centre, thus making all movement meaningful and reflective of a deeper emotional and/or social perception (Moore & Yamamoto, 2012: 30). LeFeber (2014: 465) refers to the neuroscientific work of Cynthia Berrol (2006) to explain the workings of mirror neurons. Mirror neurons' functions extend to include motor, psychosocial and cognitive operations. Dance/Movement Therapy employs the mirror neuron system not only for the individual who is executing the movement, but also for the person who is witnessing said movement, thus having a positive effect on psychosocial development.

Brehm and McNett (2007: 97) emphasise the importance of participation in sports and recreation for physical, emotional and social development as well as balance, and are convinced that dance/movement is a relevant medium through which to do this. As mentioned in Chapter 1, section 1.3.2, body image is one of the main aspects which is underdeveloped in learners with low vision, due to their limited participation in physical and recreational activities. This has a negative impact on their self-esteem and subsequent social functioning (Morse, 2004: 46).

LeFeber (2014: 465) quotes Effer (1995: 197) on the significant role of body image: “Body image is one of the most fundamental concepts in human growth and development...”. Awareness of one’s body and a consequent positive body image are fundamental in cultivating self-comprehension. A person’s body awareness develops in congruence with sensorimotor development as it is constituted of contributions from one’s vestibular, kinaesthetic, proprioceptive, visual and tactile systems (LeFeber, 2014: 465; Pylvänäinen, 2018: 23).This explains why learners with low vision experience a disparity when it comes to their body image. Movement can address this discrepancy by orientating the person with low vision’s body in terms of surrounding space and other immediate persons. This orientation occurs both intrinsically and extrinsically, thus guiding the psychosocial development which was once lacking (Effer, 1995 as cited by LeFeber, 2014: 465).

According to Cirino (2009: 12) and Devereaux (2014: 85), movement fosters interrelations with others – especially when used in a group session – as “reciprocal dialogues” can be created through engaging in movement in pairs or in groups. Such movement does not only allow clients to understand each other’s experiences, but creates the opportunity for them to share such happenings. In doing so, secure attachment relationships are established. This is an important aspect to consider for learners with low vision, as the body-based signal behaviours from their primary caregivers, which were supposed to allow for the security to explore their environment, could not be perceived from a young age, making them uncertain in space and around others (Devereaux, 2014: 86).

Tantia (2014: 95) describes Dance/Movement Therapy as a means of reaching an enlivened sense of oneself in the world, referred to as embodiment, by guiding a person to kinesthetically interact with feelings, memories and experiences, thus producing physical, emotional and social wellness. However, to benefit from this, the client must perceive his or her body as “safe” (Tantia, 2014: 96), which is a perception which, due to altered body image (Morse, 2004: 50) and spatial perception (Devereaux, 2014: 86), a person with low vision might not hold prior to Dance/Movement Therapy intervention.

Tantia (2014: 97 – 105) explains how Dance/Movement Therapy facilitates a sense of mindfulness during initial sessions and evolves into embodiment as the individual's body awareness, body image and in the end his/her self-esteem is developed and secured. Tanitia (2014: 95) uses somatic modes of attention (as cited by Csordas, 1993) to explain the progression from mindfulness to embodiment. Mindfulness can be paralleled with attention *to* the body – a subtle consciousness of one's physical, emotional and cognitive experiences. As this consciousness increases through growing self-awareness, embodiment or attention *with* the body is cultivated – a spontaneous, enlivened state which stems from feeling secure within one's own body (Tanita, 2014: 95 – 96).

Cleary (2002: 20) suggests that sensory integration should also be considered and included as part of a Dance/Movement Therapy intervention programme. Meeus (1994: 362) expands on the significant role that sensory integration plays in adapting to low vision as it influences aspects such as motivation and self-esteem, while Cleary (2002: 20) also attests to its importance. Anderson (2000: 398) furthermore explains that low vision is linked to sensory integrative dysfunction, which means that the brain is not capable of integrating and processing sensory information presented by the body and its surrounding environment, which then more often than not results in inadequate motor skills, inferior body awareness and image, hypersensitivity and even defensiveness to movement. All of these factors can also lead to low levels of self-confidence and subsequent social difficulties (Anderson, 2000: 399). Cleary (2002: 20) has found that integrating occupational therapy activities with Dance/Movement Therapy activities can address these matters.

2.8 IN CONCLUSION

From the above engagement with existing literature, it is clear that for an adolescent with low vision to be able to transcend his/her sensory impairment, specified physical, psychological and social needs have to be addressed. Also clearly indicated by the literature is that Dance/Movement Therapy is a therapeutic intervention which focuses on the somatic, emotional and social development of the client. For these reasons, this research endeavour will aim to determine whether six female adolescents with low vision who participate in a Dance/Movement Therapy intervention programme will experience enhanced psychosocial well-being through improved body image and higher self-esteem.

CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

With reference to local as well as international literature sources, the two preceding chapters were concerned with establishing a comprehensive framework of the Art Therapies in general and of Dance/Movement Therapy as a category, in particular. The concept of psychosocial well-being was also explained.

Chapters 1 and 2 also aimed at fostering an understanding of sensory impairments, with a particular focus on visual impairment, as well as an understanding of how this is comprehended and approached from a biopsychosocial rather than a purely medical or social perspective. The inclusion of constructivism was advocated, which should be included in the framework from which the concepts of visual impairment, psychosocial well-being and Dance/Movement Therapy should be studied. An outline was provided regarding the potential relevance which Dance/Movement Therapy may hold as a therapeutic medium for individuals with low vision. Based on this research, the researcher endeavoured to attend to the premise of whether Dance/Movement Therapy can be applied as a physical and therapeutic intervention as a means of improving the psychosocial well-being of adolescents with low vision.

This third chapter intends to elaborate on the design and methodology which will be implemented to investigate and subsequently gain insight into the premise that Dance/Movement Therapy could possibly yield advances in the psychosocial well-being of low vision adolescents. The research process can be explained as the methodological procedure through which information is amassed and scrutinised to ascertain associations as well as to detect discrepancies in an effort to discover an answer to a particular question (David & Sutton, 2004: 141). Therefore, this chapter concentrates on describing this process through elaborating on the research methodology which has been applied to address the conceptualisation of Dance/Movement Therapy with low vision adolescents as a possible means to better their degree of psychosocial well-being.

Research methodology pertains to the criteria which dictate the manner by means of which data is collected and analysed. It therefore determines the approach to be taken to gather and study information in an organised and logical manner in an effort to gain valid and reliable results (Jonker & Pennink, 2010: 12). This means that the term encapsulates not

only the research design, but also the duration of the study, how participants will be selected, the role of the researcher and the strategies which will be engaged in to accumulate and examine the data in an objective manner (Creswell, 2014: 16). This chapter therefore centres on the following aspects: the intention of this research endeavour, the specific research design and methods applied during this study, and the ethical considerations taken into account during the data collection process. This was done in a manner which resonates with the researched literature and the assertions made in Chapters 1 and 2.

3.2 RATIONALE OF THE RESEARCH STUDY

This research endeavour aspired to examine Dance/Movement Therapy as a form of Art Therapy and then to explore whether the implementation of a Dance/Movement Therapy intervention programme within a South African school context could contribute to improving the self-esteem and consequent psychosocial well-being of adolescents with low vision. In doing so, it attempted to answer the research question as was posed in section 1.4:
How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?

As a means of addressing this question, the following sub-research questions were investigated:

1. What will the Dance/Movement Therapy intervention programme entail?
2. How will an accepting environment which promotes ability be established?
3. How did the Dance/Movement Therapy intervention programme influence the participants' self-esteem and subsequent psychosocial well-being?

3.3 RESEARCH METHODOLOGY AND DESIGN

3.3.1 Defining the concept of research methodology and design

Creswell (2014: 31) considers one's plan for research as encompassing wide-ranging suppositions which are determinant of the approach to be applied in order to examine the study subject (one's research paradigm), the process of investigation (research design) and the manner in which data will be collected, analysed and interpreted (research method).

Salkind (2010) describes the design of research as a prescribed method applied to problem solving, deliberating and obtaining information – hence the concept of research methodology which encompasses one's theoretical construction, procedure of data gathering and mode of

analysis which may be quantitative, qualitative or a combination of the former and the latter (Salkind, 2010: 1149). As the aforementioned theoretical construction is an informative part of determining methodology and design (Johnson & Christensen, 2010: 31), the concept of a research paradigm will now be explained.

3.3.2 Defining the concept of research paradigm

Paradigm, as originated from the Greek term *paradeigma* and which loosely translates into the word 'pattern', was initially applied by Thomas Kuhn (1962, as cited by Johnson & Christensen, 2010), to describe a conceptual outline against which problems could be examined and solutions could be explained. He perceived a research paradigm as a philosophy regarding the characteristics and management of research as determined by a particular arrangement of assumptions, beliefs and values (Johnson & Christensen, 2010: 31; De Vos, 2002: 42). In more simplified terms, a paradigm refers to the way in which we observe, experience and comprehend the world around us (Killam, 2013: 4). Creswell (2014: 36) describes such paradigms as philosophical worldviews – a series of convictions which direct one's actions. According to Creswell (2014) these persuasions include post-positivist, constructivist, transformative and pragmatic frameworks (Creswell, 2014:35).

De Vos (2002: 45) justifies the significant role of selecting a research paradigm, grasping the nature of the chosen paradigm and stipulating this clearly in one's research by explaining that in doing so, the researcher's exchanges with his/her readers remains unencumbered and unequivocal. As stated in Chapter 1, this particular research endeavour was conducted from a constructivist paradigm, as the basic premises of this epistemology are comprehension, compound contributor significance, social and historical structure and theory creation (Creswell, 2014: 36). The constructivist paradigm originates from the interpretivist perspective which concentrates on individuals' subjective involvements and encounters and how they assemble their social world through shared connotations, interactions and relations. This is done through detailed, in-depth exploration of the phenomena which the researcher wishes to understand (Nieuwenhuis, 2007: 59).

According to Creswell (2014: 37), research conducted from a constructivist paradigm mainly depends on the participant's opinion and understanding of the situation being investigated, as such comprehension is fashioned through dialogue and contact made within the setting being studied. Simply stated, the researcher listens to and observes participants' communications and actions within their everyday life situations. Such subjective ascriptions are not only determined through the aforementioned social interactions, but are also shaped by historical standards and cultural customs – another reason why such research which is

approached from a constructivist paradigm is context-bound (Creswell, 2014: 37). In doing so, the researcher becomes aware of the participants' experience, and subsequent views of the studied situation result from his/her personal, historical and cultural perception thereof and, rather than commencing with a particular theory (as within a post-positivistic paradigm), ends up formulating and cultivating a premise (Creswell, 2014: 38).

Creswell (2014: 37) considers a constructivist paradigm as being an archetypal starting point to qualitative research as it guides the researcher to consider the intricacy of collected data rather than categorising such information. Furthermore, Creswell (2014: 50) also calls for qualitative research if the phenomenon to be studied is fairly new and limited research has been conducted to date in regard to this concept. Therefore, this particular research endeavour in part employed a qualitative research design – not only due to the constructivist paradigm which the subject calls for, but also because of the fact that it was established in Chapter 1, section 1.10, that Dance/Movement Therapy in general is a subject that pleads for future research. Moreover, the fact that the application of Dance/Movement Therapy as a therapeutic intervention with low vision individuals within a South African context has yielded limited information further supporte this choice of paradigm.

Creswell (2014: 50) however also suggests that if a socially based research question involves the application of a particular form of intervention such as the implementation of a programme and the measurement of an identified mindset prior to and after such an intercession, then the use of a quantitative approach which tests one's premise should be employed (Creswell, 2014: 48). The fact that this specific research effort aimed to determine whether active participation in a Dance/Movement Therapy intervention programme may influence psychosocial well-being by improving self-esteem, which was measured through the Rosenberg Self-Esteem Scale before and after the implementation of the Dance/Movement Therapy intervention programme, also supported the need for a quantitative approach to research design.

Therefore, the researcher worked from the premise that gathering assorted forms of data will provide a more comprehensive insight into the research question than what a qualitative or a quantitative approach can deliver on its own. Consequently, a mixed method approach was employed. Both qualitative and quantitative approaches will now be discussed so as to support the decision to implement both through a mixed method approach.

3.3.3 Qualitative research design

Qualitative research stems from the social and behavioural sciences, and the in-depth processes which constitute such research result in more descriptive rather than predictive data (Flick, 2009: 11). More specifically, the concept “qualitative” refers to the nature of the entities to be studied and therefore focuses on the development and significance of the study subject which cannot be determined in sum or with regularity – it is the acquiescent, objective study of subjective realities which can be adapted as the research investigation advances and evolves (Corban & Strauss, 2014: 17).

Data collection and analysis techniques are therefore more focused on oral methods than on statistical and mathematical formulae (Fouché & Delport, 2002: 80). As another means of definition, Creswell (2014: 32) explains that research of a qualitative nature surveys significant connotations which persons attribute to personal or social conditions as its emphasis is on the process which delivers comprehensive depictions of what the researcher appraises within a specific environment – thus echoing the constructivist view that the study of the selected phenomena must occur within a natural setting as the experience thereof is context-sensitive.

As opposed to quantitative research where a sizable assemblage of participants present data which is to be analysed through statistical measures, a qualitative research design employs research techniques which gather data from a smaller group of respondents that will then provide data that will be analysed in a non-statistical, but still scientifically based manner (Silverman, 2013: 6).

While both quantitative and qualitative approaches employ theory as a means of expounding human conduct and opinions, qualitative research makes use of theory as an orientating microscope through which to study and answer enquiries concerned with matters of marginalised sets of individuals with regard to aspects such as class, gender or race (Creswell, 2014: 98). One such theory that a qualitative perspective provides is the Disability Inquiry which concentrates on comprehending this group’s social and cultural outlook, and with this gained insight promotes self-efficacy rather than focusing on a biological apprehension of the physical condition (Creswell, 2014:99). Therefore the qualitative research approach supported the call made in Chapters 1 and 2 that disability in general and visual impairment specifically should be viewed from biological, psychological, social and constructivist vantage points rather than absolute medical or social models (Brittain, 2004: 429; WHO, 2002: 4; Adler, 2009: 609).

Creswell (2014: 32) explains that qualitative research generally proceeds to reveal queries and subsequent measures of action, with data being collected within the research participants' everyday surroundings. Data analysis then aims to inductively construct universal themes from the specific information which was gathered, leading the researcher to form an interpretive understanding with regard to the implications of the data – all the while acknowledging and respecting the complex nature of the human situation and maintaining an objective stance by ignoring his/her own predeterminations but rather converging around the participants' connotation and discernment of the social experience (Fouché & Delport, 2002: 80; Creswell, 2014: 42).

Within a framework of qualitative research design, there are a number of approaches that can be used to collect, analyse and interpret data which have been developed, tested and acknowledged during the 20th and 21st century, including the phenomenological method, grounded theory, ethnography and case study research (Creswell, 2014: 42). This particular research endeavour was approached as a bounded case study. Creswell (2014: 43) explains that a case study is especially employed as an approach when the field of investigation is evaluative in nature as this method allows for a detailed study of process, activity or programme – which in this case was a Dance/Movement Therapy intervention programme.

3.3.4 Quantitative research design

As briefly referred to in section 3.3.3, a quantitative research design is based on the intention of investigating a premise through numerically measuring and statistically analysing a research problem (Fouché & Delport, 2002: 79). Maree and Pietersen (2007: 145) describe this process as methodical and impartial.

Quantitative research design can be categorised into two divisions, namely experimental and non-experimental designs (Maree & Pietersen, 2007: 149). This particular research endeavour is concerned with the experimental design as its specific aim is to answer the cause-and-effect question. In other words it seeks to determine whether a particular intervention has any impact on a contingent variable through a pre-test post-test approach (Maree & Pietersen, 2007: 149).

Creswell (2014: 32) also emphasises that this research process intends to ascertain the relationship between identified measures. Furthermore, Creswell (2014: 50) considers a quantitative approach to be the most relevant method of determining the usefulness of a certain treatment. As stated previously, in this particular case, the researcher aimed to

determine whether a Dance/Movement Therapy intervention programme will influence the psychosocial well-being of adolescents with low vision by gathering and assessing data collected through a pre- and post-intervention questionnaire called the Rosenberg Self Esteem Scale (RSES).

The quantitative approach embraces a post-positivistic paradigm which suggests that the researcher formulates a theory and then gathers data which will either validate or contest the theoretical conception (Creswell, 2014: 36). Creswell (2014: 37) explains that such information is gathered through the instruments completed by the selected participants and/or by the methodical observations made by the researcher – both of which were employed to gather data during this specific research endeavour.

Quantitative research aims to form significant assertions in order to explicate the relevant situation and the pivotal associations thereof with the end objective of enhancing such relationships (Creswell, 2014: 37). One way of doing this is through survey research which provides a quantitative portrayal of viewpoints, feelings and thoughts by examining a selection of a particular population (Creswell, 2014: 42). This can be accomplished through the use of interviews or questionnaires, and considering that the Rosenberg Self-Esteem Scale is categorised as a questionnaire, this part of the research endeavour lent itself to a quantitative approach.

Therefore, as set out in sections 3.3.3 and 3.3.4, this particular research undertaking had both qualitative and quantitative elements and this is why the researcher decided upon a mixed method approach to research, which will now be discussed in more detail.

3.3.5 Mixed methods research

According to Creswell (2014: 32), mixed methods research engages both quantitative and qualitative data collection and amalgamates the two types of data – open-ended and closed-ended data – as it is believed that the arrangement of the two methods ensures a more comprehensive understanding of the research question by highlighting the strengths of both qualitative and quantitative methods, while overcoming each method's limitations. This is also referred to as mixed methodology, multi-method, qualitative and quantitative methods, integrating methods and synthesis method (Creswell, 2014: 266; Regnault, Willgoss & Barbic, 2018: 20). The height of this method's development occurred in the 1980s and 1990s within the fields of health sciences, sociology and education (Creswell, 2014: 266) as it progressed through constructive, philosophical debating, procedural advancement and

reflection stages of development until developing into a method used in many more disciplines and countries (Creswell, 2014: 267; Regnault, Willgoss & Barbic, 2018: 20).

This approach, like the qualitative method, also elaborates on the constructivist world view by advocating for marginalised population groups by adopting a transformative stance that speaks to social matters such as inequality and alienation (Creswell, 2014: 38), which had been mentioned as challenges faced by individuals with low vision in Chapters 1 and 2. A transformative world view concentrates on the needs of such individuals (Creswell, 2014: 39), which is what this particular research endeavour also aspired to do with regard to psychosocial requisites of adolescents with low vision.

Mixed methods research embraces the world view of pragmatism, as it calls for the employment of various methodologies to obtain data which addresses the research question (Creswell, 2014: 39). Therefore, the pragmatic view to research encourages the researcher to draw upon both qualitative and quantitative approaches while engaging in the research process, thus presenting the researcher with an array of techniques, procedures and methods to select from in order to best meet their research requirements (Creswell, 2014: 39). Furthermore, a pragmatic standpoint concurs with the transformative view which suggests that all research takes place within social, historical and political spheres and therefore should cater for a paradigm which accommodates such purposes as well (Creswell, 2014: 40). The use of a mixed methods approach is best summarised and advocated by Creswell in the following statement: “Thus, for the mixed method researcher, pragmatism opens the door to multiple methods, different world views and different assumptions, as well as different forms of data collection and analysis” (Creswell, 2014: 41).

Furthermore, according to Creswell (2014: 43), the use of varied research methods was applied as early as 1959 to measure psychological attributes. Since then, it has incited further research that employs multiple methods such as observations and surveys in an effort to eliminate bias and other research limitations (Creswell, 2014: 43). Taking into account that self-esteem and well-being were classified as psychological traits and that the researcher aimed to employ observation, a research diary, journaling and a questionnaire as data collection techniques, the use of the mixed method paradigm appeared to be the most appropriate.

The fact that the research problem calls for the determination of not only the usefulness of an intervention programme, but also for a greater degree of research on the topic of Dance/Movement Therapy specifically with the sample group of individuals with low vision,

both quantitative and qualitative approaches are suited (Creswell, 2014: 48). The researcher's personal experience also influenced the decision to make use of a mixed method approach as she valued the organisational structure which quantitative research provides, but also appreciated the tractable and adaptive nature of qualitative data collection (Creswell, 2014: 51). The literature review as presented in Chapter 2 furthermore reflected the mixed method approach as it contains both qualitative and quantitative approaches to literature (Creswell, 2014: 61).

With regard to the social sciences, there are three principal archetypes of mixed methods research: convergent parallel, explanatory sequential and exploratory sequential mixed methods (Creswell, 2014: 44), thus again supporting the choice of employing a mixed methods approach which allows for the strengths of both qualitative and quantitative research methods to be applied.

Convergent parallel mixed method is a mode of mixed methods research strategy where qualitative and quantitative data is combined to comprehensively analyse the research problem. These two types of data are collected at more or less the same time and then merged in order to interpret research results in a thorough and all-inclusive manner (Creswell, 2014: 44). Through an explanatory sequential mixed method of research, the researcher first engages in quantitative research before expanding on the quantitative data analysis by conducting qualitative research as a means of explaining and elaborating on initial findings (Creswell, 2014: 44). The exploratory sequential mixed method on the other hand is where the research process is initiated through qualitative data collection to investigate the opinions, feelings and thoughts of the research participants. This information is then applied in quantitative research methods by designing quantitative research tools such as surveys and questionnaires which will be employed in the second, quantitative phase of the mixed methods approach to research (Creswell, 2014: 44).

A convergent parallel approach can be encompassed in a social framework that focuses on assisting a marginalised group such as individuals with disabilities, as was mentioned earlier in this section as well as in section 3.3.3 (Creswell, 2014: 278). This is an advanced method called transformative mixed method. A transformative mixed method encloses many aspects of the study including the research problem, the research questions and processes of gathering, analysing and interpreting data (Creswell, 2014: 278). This particular research study, which focused on the influence of a Dance/Movement Therapy intervention on the psychosocial well-being of adolescents with low vision, therefore adopted a convergent

parallel approach within a transformative mixed method framework as the transformative nature of Dance/Movement Therapy had already been established in 1.3.2.

The reasons for this choice were based on various factors. Firstly, it was founded on the presumed outcome of the study (Creswell, 2014: 281), which anticipated a link between a Dance/Movement Therapy intervention programme and the psychosocial well-being of adolescents with low vision. Secondly, the choice was based on how the data would be integrated (Creswell, 2014: 281). To be able to determine whether the previously mentioned expected connection between a Dance/Movement Therapy intervention programme and the psychosocial well-being of adolescents with low vision existed, qualitative and quantitative data were merged to determine convergence or divergence of the two data sets. Another aspect associated with the choice of method was the timing of the data collection (Creswell, 2014: 282). As the data was collected simultaneously during this particular research process, a convergent approach had been decided upon. The emphasis placed on either qualitative, quantitative or both strategies further influenced the choice of approach (Creswell, 2014: 282). In view of the fact that the researcher deemed both the qualitative and quantitative processes to be equally important, a convergent parallel approach to data collection, analysis and interpretation was once again called for.

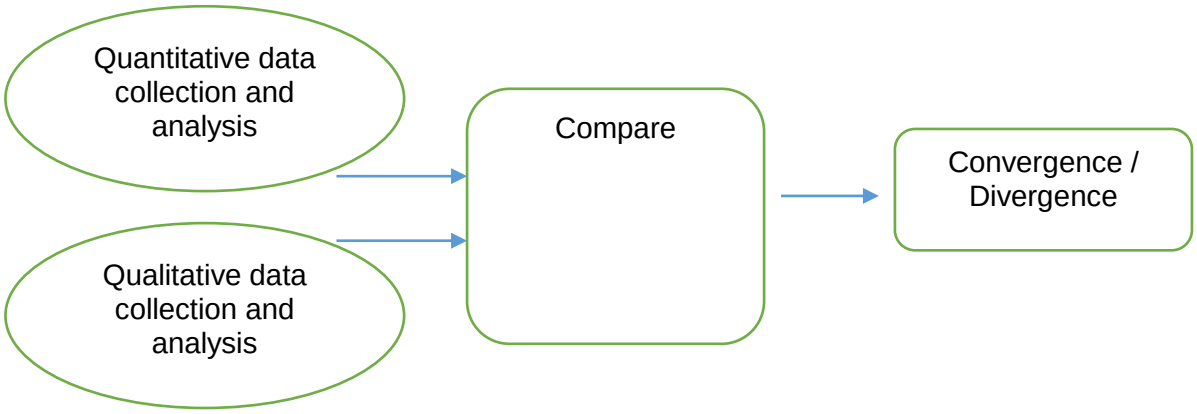


Figure 3.1 Convergent parallel approach to data collection, analysis and interpretation

3.4 RESEARCH METHODS AND TECHNIQUES

3.4.1 Site selection and sampling selection

3.4.1.1 Selection of the site

The selection of a research site involved deciding on a setting which met specific criteria that allowed for access to participants who provided prolific information while also suiting the research study and its particular design (Ebersöhn, Eloff & Ferreira, 2007: 129; McMillan & Schumacher, 2010: 326). The criteria included suitability for collecting research data as well

as practicality in terms of the skills, time and resources with which the researcher is equipped (Ebersöhn, Eloff & Ferreira, 2007: 129; McMillan & Schumacher, 2010: 351).

The site which was identified for this particular research study was a school for visually impaired learners situated in Gauteng. This school encompasses grades 0 through to 12 and is divided into a mainstream section, a section for special education and also a section for severely intellectually disabled learners. Class sizes do not exceed 25 learners per class. The learners who attend this school come from diverse cultural and socio-economic backgrounds. This educational institution has been in existence for more than 50 years and is equipped with a wide range of facilities and auxiliary services including a school nurse, an eye clinic, a centre for occupational therapy and mobility training, a school psychologist located on the premises, two school halls, a gymnasium, a sports field and a swimming pool. As stated in Chapter 1, section 1.3.1, the school presents the learners with a wide range of cultural activities such as singing and mastering of various musical instruments but does not present many opportunities for sport and other physical pursuits. Therefore, as this is an educational institution with the enrolment criteria of visual impairment and that presents grades 6 to 12 which includes adolescent learners, the researcher was able to gather data relevant to this particular research endeavour. The necessary resources in terms of facilities, equipment and supporting staff were available, with the gymnasium, one of the two halls or one of the play rooms in the occupational therapy centre available for use in accordance with the school's extra-curricular time table. The school had stereo equipment as well as musical instruments such as djembe drums available.

As explained in Chapter 1, section 1.8, the school has a mainstream section that follows an unadapted curriculum, which meant that the Life Skills/Life Orientation educators could assist in identifying possible participants who had low self-esteem as was proposed. The school psychologist could also provide her expert opinion in the participant selection process and the school nurse was available in case of injury as the possibility existed that participants (with low vision) could for example bump into each other, although every measure was put in place to ensure the physical safety of learners.

Although the researcher does not consider her own convenience as important, the fact that she worked at the particular institution and lived within 15 kilometres of the school, supported the research process in terms of time spent on travelling to and from the research site. Finally, the fact that the researcher had been working at this particular institution for ten years, equipped the researcher with valuable skills for working with visually impaired learners in terms of their various eye conditions and how these would relate to their ability to

participate in physical activities. The researcher did acknowledge the ethical issue pertaining to role confusion between teacher and researcher which will be addressed in section 3.6.

3.4.1.2 Sample selection

Sampling refers to the selection of persons who will take part in the research study – in other words the approach which will be employed to choose participants from the larger population and from whom data will be collected and then used to epitomise the greater group (Strydom & Venter, 2002: 197 – 199; Maree & Pietersen, 2007: 172; McMillan & Schumacher, 2010: 129). With regard to this particular research endeavour, the sample consisted of adolescent females who had been diagnosed as having low vision and who had been identified as having low self-esteem. As described in the section on site selection, the researcher endeavoured to collect information from participants within a context that catered for visually impaired learners between grades 0 to 12 which would enhance the study by producing data that would provide a greater comprehension of the research topic. Therefore, the researcher used a purposeful sampling method.

According to Maree and Pietersen (2007: 172 – 178), there are two main sampling methods, namely probability sampling methods and non-probability methods. Probability sampling methods mean that an objective mechanism is employed when selecting participants and can be done through any of the four following methods: simple random sampling, systematic sampling, stratified sampling and cluster sampling (Maree & Pietersen, 2007: 172; Strydom & Venter, 2002: 203 - 206). Non-probability sampling does not randomly select participants and holds advantages in situations where time and money are limited, a measuring instrument needs to be tested in the case of survey design, or if a very specific population group is included in the research study (Maree & Pietersen, 2007: 176 – 177; Strydom & Venter, 2002: 206 – 207). This includes methods of convenience sampling, quota sampling, snowball sampling and purposive sampling (Maree & Pietersen, 2007: 177 – 178, Strydom & Venter, 2002: 206 – 208).

Bearing in mind that the studied population was very specific in terms of visual impairment, non-probability sampling was used in this particular research effort. As already stated, the non-probability sampling method of purposive sampling was employed as it is a method used in particular circumstances with a specific purpose in mind (Maree & Pietersen, 2007: 178; Strydom & Venter, 2002: 207). The researcher therefore intentionally chose a specific sample group that she considered to be “experts” as a case study to exemplify the subject

being researched by supplying data that responds to what the study aims to address. Expert sampling is a simple sub-type of purposive sampling.

The criteria according to which research participants were chosen are the following:

- They must be diagnosed with the visual impairment of low vision.
- They must be female adolescents between the age of 13 and 17.
- They must be identified as having low self-esteem.
- They must not have any previous dance/movement background or training which might contaminate research results.
- They must not presently be receiving any other form of therapy which might bring the research results into question.

Rhythm and musicality was not considered as a prerequisite for participation. Furthermore, as some religions are opposed to wearing clothes that are revealing, such as the physical education kit, and others prohibit dancing or listening to certain types of music, the researcher was sensitive to these factors.

As stated in the section on site selection, the school's criteria for enrolment is that a learner's vision must be affected to such an extent that he/she cannot function in a mainstream school. Each prospective learner undergoes an eye examination by the school's nurse and an ophthalmologist prior to enrolment, to determine whether he/she is a candidate or not. Therefore, learners who are not diagnosed as legally blind but who have a visual acuity lower than 20/70 which cannot be corrected or improved through the use of normal glasses or contact lenses are considered to have low vision and were therefore eligible to participate in the research study. Also stated in the previous section on site selection, was the fact that the school includes both primary and high school learners, starting from grade 0 and extending to grade 12. It is also a school which caters for both male and female learners. Therefore, it was possible to identify female learners with low vision between the ages of 13 to 17 from grade 6 upwards.

Personal and Social Well-being (PSW) is a focus area which forms part of the Life Skills/Life Orientation curriculum for Grades 4 to 9 and includes evaluative sections on self-esteem. Consequently, grade 6 to 9 educators who teach Life Skills/Life Orientation were able to identify female learners who had low self-esteem. The school psychologist, occupational therapists and mobility instructors also assisted in the identification process. In requesting these parties to take part in the initial identification process, bias on the part of the researcher was avoided. Teachers and multi-disciplinary staff members were approached individually and discreetly and requested to indicate on a class list the degree of self-esteem

of each female learner between the ages of 13 and 17 on a scale from 1 to 5 (1 being very low, 2 being low, 3 being adequate, 4 being high and 5 being very high).

Learners who were scored a 1 were further compared to the remaining above-mentioned selection criteria to additionally refine the selection. Five questions were also asked in an informal manner of these prospective participants to attain an additional indication of their level of self-esteem and thus refine the selection process even further. These questions were conceptualised after studying various online self-esteem tests which all more or less came down to the following:

- Are you afraid of being criticised or rejected by others?
- Do you feel that you don't have what it takes to socialise with other people?
- Do you often feel that you are letting other people down?
- Do you feel that if you are yourself, others do not like you?
- Do you need someone to compliment you before you feel confident in what you are doing?

The six participants who answered "yes" to the most of these questions were approached to participate in the research process and the researcher then continued with the process of gaining consent and assent from the necessary parties. The sampling comprised a discreet process as it would have been unethical to create the impression that learners could be included as participants, only to be disappointed if not included.

3.4.2 Data collection

As has been explained in Chapter 1 as well as in section 3.3.5, the researcher intended to collect data with regard to self-esteem as well as data concerned with the influence of a Dance/Movement Therapy intervention programme at more or less the same time and then combine the results to determine whether the intervention programme had an influence on the self-esteem and subsequent psychosocial well-being of adolescent females with low vision. Therefore, this particular research endeavour employed a convergent parallel mixed method pertaining to data collection so as to compare information drawn from qualitative and quantitative data. A more comprehensive understanding of possible transformations in the self-esteem of individuals with low vision was thus created, by combining the open-ended data from the researcher's observations and the participants' reflections, as well as the closed-ended data of the questionnaire, and developing a greater comprehension of the need for and influence of a DMT intervention programme by amalgamating both qualitative and quantitative information (Creswell, 2014: 267).

Creswell (2014: 269) considers the convergent parallel mixed method to be the most conversant and progressive of the mixed method approaches as it extends from the multi-method concept of Campbell and Fiske (1959, as cited by Creswell, 2014: 269), which considers psychological qualities to be better comprehended as a result of collecting various forms of data. When implementing this approach, the researcher gathers qualitative as well as quantitative data at the same time, and then studies each data set independently in order to compare the findings and determine whether the results verify each other or not (Creswell, 2014:269). The method of qualitative data collection can be conducted through interviews, observations, documents and archives, while the quantitative data can be instrument data, observational checklists or numeric records as long as the same concept is used to collect both sets of data and the same participants are used for both data collection strategies (Creswell, 2014: 269).

This research endeavour employed the following data collection strategies: the quantitative measure of the Rosenberg Self-esteem Scale (RSES) and the qualitative strategy of observation, process notes in a researcher's diary and participants' written reflections in their personal DMT Journey Journals. Herewith follows the framework of the sessions during which the data collection strategies were employed:

- Session 1: Completion of the Rosenberg Self-Esteem Scale (pre-intervention test) (cf. Addendum O).
- Sessions 2 – 9: 1 hour sessions of a Dance/Movement Therapy intervention programme twice a week, including written reflections by participants at the end of each session. These sessions were recorded on video to enrich the recording of observations on an observation schedule (cf. Addendum I). Process notes logged in a researcher's diary (cf. Addendum J) were also employed while studying the videos.
- Session 10: Completion of the Rosenberg Self-Esteem Scale (Post-intervention test) (cf. Addendum P).

Each data collection strategy will now be discussed in more detail:

3.4.2.1 Questionnaire - The Rosenberg Self-Esteem Scale

A questionnaire is a research tool which is comprised of a series of questions through which individuals are queried as a means of gathering data concerning a particular subject (Maree & Pieterson, 2007: 156; McMillan & Schumacher, 2010: 423). Through such an enquiry, information regarding the attitudes, values, habits, ideas, demographics, feelings, opinions, perceptions, plans and beliefs of a particular group of people can be determined (Maree & Pietersen, 2007: 155).

Such a questionnaire was employed during this empirical research process to ascertain the degree of each participant's self-esteem before and after the implementation of a Dance/Movement Therapy intervention programme. Therefore, the questionnaire was administered to each research participant in a group prior to and after the first and the final Dance/Movement Therapy session respectively. The conclusions gathered from each respective participant's pre- / post-intervention questionnaire were equated to determine whether the levels of self-esteem of each individual participant had altered.

The Rosenberg Self-Esteem Scale (RSES) (cf. Addendum H) was employed as a measuring instrument to determine the above. It is a 10-point scale which measures universal self-worth by gauging both positive and negative perceptions about the self (Schmidt & Allik, 2005: 623). It is a self-report instrument designed to evaluate individual self-esteem through a 4-point Likert-scale format which ranges from strongly agree to strongly disagree as responses (Schmidt & Allik, 2005: 623). The RSES is proportionately partitioned to assess two 5-item aspects of self-esteem (SE): namely self-competence (SC) and self-liking (SL) (Sinclair, Blais, Gansler, Sandberg, Bistis and LoCicero, 2010: 57). Self-competence, which is defined as feeling confident and capable, is considered to be an individual's instrumental value, while self-liking, which is surmised as feeling socially relevant, is viewed as one's intrinsic value (Sinclair et al., 2010: 57).

The above once again underlines the psychological and social elements of self-esteem and echoes why self-esteem is a determining factor in psychosocial well-being, as has been discussed in Chapter 2.

Sinclair et al. (2010: 57) state that due to its simplistic format, brevity and face validity, the Rosenberg Self-Esteem Scale (RSES) is one of the most commonly used instruments to determine self-esteem. Schmidt and Allik (2005: 624) further affirm this notion by stating that the RSES exhibits a clear, one-dimensional factor structure. It has been applied in 199 research projects with an entirety of 65,965 participants (Sinclair et al., 2010: 57). Sinclair et al. (2010: 58) confirm that there is substantiation which supports both the scale's structural and predictive validity along with its internal consistency and test-retest reliability. A Cronbach coefficient of M=0.81 endorses the internal coherence across cultural settings (Sinclair et al., 2010: 59). Schmidt and Allik (2005: 623) also found a cross-cultural equivalence of the RSES.

The RSES was enlarged to an A3 format to accommodate the participants' eye sight, administered pre- and post-intervention to the 6 selected participants respectively in sessions 1 and 10 in a group format and no further quantitative data was gathered during sessions 2 to 9. With each administration, the researcher relayed instructions and permitted questions to clarify any directives. The participants were then directed to write their names on the questionnaire in order to identify and match individual pre- and post-intervention results. These names were later erased and replaced with Participant A – F to ensure anonymity. Although administered in a group, each participant completed the questionnaire confidentially and returned the document face down inside a file organiser. Only the researcher saw the pre- and post-intervention RSES questionnaires and the subsequent results.

The pre-intervention results were employed to determine a particularised preliminary score for self-esteem for each participant which would then be placed in parallel with respective post-intervention findings in order to determine any variation in self-esteem across the extent of the investigation due to the implementation of a Dance/Movement Therapy Intervention Programme.

This data regarding individual self-esteem was then studied concurrently with information gained from the DMT Journey Journals, the observation schedules and process notes; in so doing, advanced comprehension with regard to the influence of a Dance/Movement Therapy intervention programme on the psychosocial well-being of adolescent girls with low vision was gained. The use of this psychometric measure further limited possible bias from the researcher.

3.4.2.2 Observation and process notes in a researcher's diary

Observation involves a systematic method of recording significant occurrences and behavioural archetypes during each session – in other words it entails the researcher continuously taking note of what he/she sees and hears as it naturally unfolds during intervention and reflection. Because the researcher is able to observe, he/she is privy to ample data provided through the behavioural patterns, natural reactions and non-verbal prompts of each participant, which provides him/her with a deeper insight into what is unfolding (Nieuwenhuis, 2007: 83; McMillan & Schumacher, 2010: 350).

An observation schedule (cf. Addendum I) and process notes in a researcher's diary (cf. Addendum J) were utilised to document what the researcher saw and heard while studying the video recordings of each respective Dance/Movement Therapy session. Both of these

instruments were then applied as means of analysis and reflection on what had taken place in each session.

The observation schedule is a document which is configured before the process of amassing information takes place, in order to demarcate conduct and circumstantial aspects which are discerned and chronicled throughout the study (Given, 2008: 576). A qualitative observation schedule serves as an acquiescent parameter to direct the researcher's surveillance, noting information and enumerating arising premises. Observation schedules also assist in managing time and show the regularity and succession of occurrences in order to identify emerging topics (Given, 2008: 576). The observation document is comprised of classifications that originate from the research endeavour's objectives, and objective records, participant actions and comments as well as associations between participants are recorded (Given, 2008:576). The observation schedule particular to this research endeavour was roughly constructed around Laban's Movement Analysis (LMA) as was discussed in Chapter 2 (Langton, 2007: 17; Hackney, 2002: 237). It included aspects of shape, effort, range of movement, space, recurring patterns and movement preferences as well as facial expressions, while also providing the option of adding additional observations.

Process notes are an extension of the observation schedule as extensive, illustrative specifics of not only the participants, but also of the researcher, are included and reflections on information, configurations and the course of occurrences are also documented. These notations are made in a personal journal, otherwise known as a researcher's diary (Given, 2008: 341). A researcher's diary expedites the progression of the investigation through documentation of observations, deliberations and queries as these occur, allowing the researcher to refer back to such citations for use later on, and also encouraging contemplative meditation about the study in general (Newbury, 2001: 2). The reason for including a researcher's diary in the data collection process is because research which is conducted with a communal and/or educational backdrop is typically perceived in a subjective manner because the importance of the information collected correlates with the value of the rapport which is established between the researcher and the participants in the research setting (Newbury, 2001: 3).

Newbury explains the value of a researcher's diary as follows:

> "The research diary provides a form through which the interaction of subjective and objective aspects of doing research can be openly acknowledged and brought into a productive relationship. In purely practical terms, it is often very difficult to separate out the writing of purely descriptive observational process notes; as one

> records particular events, theoretical concepts, or other leads to follow up, often come to mind. The value of the diary form is that it does not exclude the recording of these in relation to more objective descriptions. The research diary can be seen as a melting pot for all of the different ingredients of a research project – prior experience, observations, readings, ideas – and a means of capturing the resulting interplay of elements" (Newbury, 2001: 3).

Although there are no formal stipulations on how a researcher's diary should be kept, the researcher must have a tactic approach to note taking that accommodates the character and requirements of the particular research endeavour, and that is practicable for the researcher (Newbury, 2001: 4). In this case the researcher took on the role of a participant as observer, which means that she was part of the research endeavour as she worked with the research subjects by designing, developing and implementing the intervention strategies and therefore gained an emic perspective of the situation (Nieuwenhuis, 2007: 85). This of course means that the researcher had to be aware of her own biases and attempted to remain objective throughout the research process (Nieuwenhuis, 2007: 84).

There were also immediate logistic implications with regard to the role of participant as observer: the researcher presented the programme and was not able to observe the participants directly. Subsequently, sessions were recorded on video with a wide angle camera on a tripod. The researcher then studied the recordings after each session, completed the mentioned observation schedule and as previously described, recorded process notes in a researcher's diary which were then coded for interpretation. The fact that the Dance/Movement Therapy sessions would be recorded on video was included in the consent and assent letters (cf. Addenda F and G) as well.

Subsequently, to accommodate the needs mentioned above and the nature of the study, and to make the recording of data workable for the researcher within these circumstances as Newbury (2001:4) proposes, the researcher designed the researcher's diary based on the concept of running records, which provide comprehensive, unremitting and consecutive interpretations of that which is observed by concentrating on both actions as well as the situation and therefore explaining engagements within the context in which they transpire (Nieuwenhuis, 2007: 85). These records encapsulated two aspects of observation: the researcher's description of what was observed and her reflection on these occurrences (Nieuwenhuis, 2007: 86). This did not only expedite the data recording process but also limited the possibility of bias on the part of the researcher by contextualising and ruminating on what was observed.

3.4.2.3 A Dance/Movement Therapy intervention programme

Eight1 hour sessions were conducted after school on Tuesday and Thursday afternoons from 14:30 – 15:30. In this way, participation in the Dance/Movement Intervention Programme did not compromise the learners' academic programme, lunch or study time. They also still had 30 minutes to relax and socialise before commencing with afternoon study. The complete programme, with respective descriptions of each session as well as the audio tracks which were used, is included as an addendum (cf. Addendum K).

3.4.2.4 Participant reflection in their personal DMT Journey Journals

As explained in Chapter 1, section 1.8, the use of journals during the reflection process is a qualitative data collection technique, through which participants convey their experiences, opinions, sentiments and contemplations narratively in order to authenticate participant experiences within their natural settings (Hayman, Wilkes & Jackson, 2012: 27). At the end of each session, the participants reflected in their personal DMT Journey Journals (cf. Addendum L) and these written reflections were then studied and coded for possible themes. The researcher opted for written reflections as a means of fostering the accepting and ability-promoting environment which is proposed in one of the supplementary research questions and also called for in order to promote effective intervention through Dance/Movement Therapy (Payne, 2008: 35; LeFeber, 2013: 135) by acknowledging the fact that due to their low levels of self-esteem, the participants might not initially have been prepared to vocalise and share their thoughts and feelings about what transpired during the DMT sessions.

The option of sharing their reflections was included in each session as it was hoped that as the programme progressed and group cohesion and a sense of trust were nurtured, the participants would more readily share their reflections with the rest of the group. The participants also signed a confidentiality agreement in which they undertook not to divulge information about other group members (cf. Addendum N).

The personal DMT Journey Journals were printed in 18 size font with wider, bold lines to write on so as to accommodate the participants' low vision. Medium to thick liner black pens were provided to the participants in each session with which to write down their reflections. Most learners with low vision write at a similar speed to that of individuals with a normal range of sight, unless the learner has to intentionally write slower to keep his/her handwriting legible (Sticken & Kapperman, 2010: 106). Participants were given 10 minutes to complete their reflections. This time for reflection was planned into each Dance/Movement Therapy

intervention session and therefore did not interfere with the participants' dance/movement time. To prepare the participants for the reflection process and to optimally utilise the 10 minutes allocated for this activity, the researcher read the questions to the participants prior to their writing their reflective feedback in their journals.

In order to safeguard the information which the participants shared in their DMT Journey Journals, the researcher collected the journals at the end of each session for safekeeping until the next session. Although each activity that forms part of the particular Dance/Movement Therapy intervention session was allocated a certain time slot and limit so as to complete the session within the proposed 60 minute time frame, a Dance/Movement Therapy session should also be flexible enough to accommodate the immediate needs of each respective participant (LeFeber, 2013: 134); therefore, should any participant have required more time to process her thoughts and feelings with regard to the specific DMT intervention session, she could have approached the researcher and requested her personal DMT Journey Journal to reflect at a later stage, as long as it was completed before the next intervention session.

Participants and their parents were informed through their respective consent and assent letters that copies of their personal DMT Journey Journals would be kept by the researcher after the completion of this particular research study and that these documents would be stored securely for a period of five years, after which all evidence of these reflections would be shredded. Each participant was allowed the option of keeping her original personal DMT Journey Journal after the completion of this research endeavour as studying their reflections after the conclusion of the programme may provide valuable food for thought and promote further personal growth.

3.5 DATA ANALYSIS AND INTERPRETATION

With regard to data analysis, the qualitative and quantitative data collected through the convergent parallel mixed method strategy can be merged in various manners: either through side-by-side comparisons, data transformation or a joint display of data (Creswell, 2014: 273). Should the researcher apply a side-by-side comparison as a method of analysis, he/she will initially convey the quantitative findings statistically and then proceed to discuss qualitative results in the form of themes in order to verify or refute the quantitative findings (Creswell, 2014: 273). If the researcher amalgamates the two sets of data by altering the qualitative themes or codes into quantitative concepts in order to merge the two quantitative databases, he/she would then be employing a data transformation approach to

data analysis (Creswell, 2014: 273). In the case of a joint display of data, the two sets of data would be unified in a table or a graph (Creswell, 2014: 273).

In this particular research endeavour, the researcher first relayed the quantitative data results and then compared these findings to the themes that had stemmed from the qualitative results and therefore employed a side-by-side comparison method to analyse the collected data.

3.5.1 Analysis of quantitative data

The RSES was administered and scored according to the manual prior to the implementation of the Dance/Movement Therapy intervention sessions as well as after the completion thereof. According to the RSES, scores between 15 and 25 indicate a normal level of self-esteem, while scores of 15 and lower are indicative of a low self-esteem range. Each participant's pre- and post- test scores were then compared to determine whether her level of self-esteem had proliferated, remained constant or degenerated. It was also established whether any of the participants' pre- and post- test scores had altered to the extent that she moved from the low self-esteem range to a normal scope of self-esteem or vice versa.

3.5.2 Analysis of qualitative data

The above analysis of themes pertained to the qualitative data as collected through the observation schedules, process notes recorded in the researcher's diary, and the participants' reflections in their personal DMT Journey Journals were analysed through a coding process. Saldana (2009: 3) describes a code within the framework of qualitative enquiry as a word or brief phrase which figuratively appoints a cumulative, relevant and reminiscent feature for a segment of language-founded or graphic data which can comprise interview transcripts, participant observation process notes, journals, papers, literature, objects, videos, photographs, e-mail correspondence, websites, and so forth.

Coding is a process of investigating and problem solving which classifies and connects data to formulate an idea and then relates all the data which pertains to that particular idea to form a category, which then encompasses collective or mutual codes that pertain to the research question (Saldana, 2009: 8). This process recurs in nature as second, third or even fourth cycles of recoding further refine characteristics of the qualitative data by sifting, organising and emphasising the information to identify groupings and themes (Saldana, 2009:8).

The above is accomplished by studying the mentioned categories in order to identify communal configurations or patterns such as regularity, succession or progression, parallels, disparities, causal relationship and/or equivalence. When main groupings are then evaluated, contrasted and amalgamated, themes will emerge and the once-concrete data will be conceptualised and contextualised into theoretical frameworks (Saldana, 2009: 11).

For the purpose of this research endeavour, first and second cycle coding procedures were applied. First cycle coding refers to the straightforward, unequivocal methods that are employed during the preliminary coding of data (Saldana, 2009: 45). Second cycle coding on the other hand, requires analytical proficiencies such as categorising, ranking, assimilating, amalgamating, extracting, hypothesising and constructing theory and is therefore more perplex (Saldana, 2009: 45).

For first cycle coding, descriptive and process coding were employed. Descriptive coding encapsulates the principal theme of an extract of qualitative data as a word or concise phrase (Saldana, 2009: 70). Saldana (2009: 70) states that descriptive coding is a suitable option when analysing journals, diaries and process notes, which is what this research endeavour aspired to do. Process coding singularly denotes action such as regular perceptible activity as well as more abstract actions such as that of body language, within the qualitative data (Saldana, 2009: 77). This method of coding also seemed an appropriate choice of data analysis, as Saldana (2009: 77) explains that it is most suitable for studies which aim to examine interaction and emotion in response to a specific situation, which is what a Dance/Movement Therapy intervention programme would evoke and which would be recorded on the observation schedule.

With regard to second cycle coding, focused coding was utilised. Focused coding seeks to identify codes from the first cycle coding process which are most recurrent and substantial, and in so doing, to develop key categories or themes from the initially coded data (Saldana, 2009: 155). Through this procedure, the collected qualitative data was further refined in order to answer the question: How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?

A qualitative study on its own can amass a great degree of data – mixed methods self-evidently even more so and this ample amount of data needs to be administered in a manageable manner in order to enable proper analysis and interpretation thereof (McMillan

& Schumacher, 2010: 379). To make this process manageable, the researcher developed a coding pattern by executing the following steps, as suggested by Saldana (2009: 6):

- Prior to commencing with this process, the researcher created an electronic document in Microsoft Word containing a four-columned table.
- The four columns indicated the data collection procedure, the relevant data excerpt, word or phrase summarising the data segment, colour coded words or phrases and recurring or intersecting codes respectively.
- The researcher then studied each separate data set and underlined significant excerpts manually to determine relevant data segments.
- The data collection procedure (observation schedule, process notes from the researcher's diary or the participants' DMT Journey Journal reflections) was entered into the first column.
- The relevant data excerpt was then entered into the second column.
- Words or phrases indicating significant resemblances, distinctions, regularities, cycles, correlations or causativeness were then highlighted in the second column with different colours (Saldana, 2009: 6).
- These colour coded words or phrases were then carried over to the third column.
- The colour coded words or phrases made it easier to identify recurring or intersecting codes which were then indicated in the final column.
- The researcher then used the fourth column to compile a list of key codes, significant codes and remaining codes.
- The researcher then studied the listed codes to formulate categories from the main and important codes. The core categories or patterns were then employed to formulate a theoretical construction within which findings were organised and reported to eventually compose customary accounts concerning associations relating to these categories or patterns (McMillan & Schumacher, 2010: 373).

3.5.3 Comparing the quantitative and qualitative data

With regard to data interpretation, the comparative reports of the two data sets and the comments on whether convergence or divergence had been reached between the two were included in a discussion section of the research study (Creswell, 2014: 273). Disparities in scales, themes and theories and possible supplementary steps to further investigate and gather superfluous data to settle differences were also mentioned or such variances were discussed as possible limitations to the study (Creswell, 2014: 273).

3.6 ETHICAL CONSIDERATIONS

Taking into account that the objects of research in the social sciences are human beings, inimitable, complex ethical dilemmas are imminent as the obtainment of data must never be at the expense of the research participants (Strydom, 2002: 62). In order to guide the researcher to make conscientious decisions during the research process, ethical principles should be considered continuously throughout the research process.

Ethics refers to a series of commonly consented moral values that stipulate laws of expected behaviour to ensure the most appropriate conduct with regard to research participants as well as respondents, employers, sponsors, assistants, students and other researchers (Strydom, 2002: 63).

The researcher took the following ethical considerations into account during the entire research process:

- *Informed consent and assent:* The researcher obtained informed consent and/or assent from all institutions, stakeholders and participants involved in the research endeavour. This involved providing all the of the mentioned parties with sufficient information in regard to the goal of the research, procedures to be followed during the research process, potential advantages, disadvantages and risks to which participants might be subjected, and also the researcher's and the study supervisor's credentials (Strydom, 2002: 65). Prior to the commencement of the empirical research, the researcher obtained ethical clearance from the tertiary institution through which she is studying (cf. Addendum A), permission from the Department of Education (cf. Addendum B), as well as the school's governing body and the school principal (cf. Addenda D and E). Written consent was also obtained from the participants' parents or legal guardians and participants provided their own written assent as well (Addenda F and G). As cited by Strydom (2002: 65) above, the involved parties were informed about the following:
    - The study's purpose and constituting procedures, including the identified setting and stipulated time frame.
    - The credentials of the researcher, the study's supervisor and the research institute.
    - Possible disadvantages and risks that participants might be exposed to, including the slight, but still possible, risk of physical injury and emotional discomfort during the dance/movement activities and the process of self-exploration and reflection respectively.

- Potential benefits which might emerge from taking part in the research study, such as the numerous advantages mentioned in Chapter 1, that come from engaging in physical activity more frequently, the introduction to new means of self-expression as well as improved self-esteem and overall psychosocial well-being.
- The rights of each individual as a research participant, including anonymity and confidentiality and the fact that any participant is at liberty to withdraw from the research proceedings at any given time.

- *Privacy, anonymity and confidentiality:* Strydom (2002: 67) explains these concepts as that which should not normally be revealed to or observed by others. It is each individual's right to determine to whom, when, where and to what extent his/her actions, convictions and feelings may be revealed (Strydom, 2002: 67). This implies that information regarding the setting must be concealed by not stipulating the exact location and name of the research site. The same applies to the names of the research participants, so as to guard the participants' anonymity and the confidentiality of their written and verbal feedback not only from others in the same setting, but also from the universal reading populace. For this reason the professionals involved in the sampling selection process and the selected 6 participants signed a confidentiality agreement (cf. Addenda M and N).
- *Trust and empowerment:* Deception of the participants was circumvented by informing the subjects of all facets of the study (Strydom, 2002: 66). In so doing it was hoped that no participant would feel deceived upon the release of the research findings. Furthermore, being fully informed might possibly promote a sense of control over the research process for each participant and hopefully foster a sense of empowerment which would extend beyond the research process (Strydom, 2002: 67; McMillan & Schumacher, 2010: 339).
- *Actions and competence of the researcher:* Strydom (2002: 69) emphasises the importance of the researcher being amply competent and skilled to assume the proposed research endeavour. The researcher was equipped with the needed qualifications and experience to engage in this particular study in a professional manner and also to handle therapy and research results ethically, with the necessary objectivity as well as emotional and cultural sensitivity. It was the priority of the researcher to maintain integrity and follow a strict code of ethical conduct to ensure that participants were safeguarded against any possible detriment. Finally, as mentioned when discussing informed consent, such qualifications and experience were presented to all stakeholders, participants and their parents.

- *Role of the researcher versus educator:* As stated in 3.4.2.2 the researcher must continuously be aware of remaining objective and unbiased throughout the research process. In sections 3.4.1.2 and 3.4.2.1 it was mentioned that initial selection was done by persons other than the researcher and that a psychometric measure in the form of the RSES was employed to determine the participants' level of self-esteem. Both of these strategies limited the probability of researcher bias considerably. While the participants' existing relationship with the researcher might influence their observed behaviour as they might feel obligated to assist their teacher in successfully completing her research project, the fact that this relationship promoted a certain level of trust, familiarity and established rapport could enrich the research process, should also be weighed. Finally, as was mentioned in section 3.4.1.1 the researcher's role as educator had also equipped her with skills which were unique and valuable to this particular research setting.
- *Publication of the research findings:* The written form of the study's findings which will be released to the reading populace must be credible and transferable (Strydom, 2002: 71). This means that the publication of the research findings must be an accurate reflection not only of the subject studied but also of the process followed (Strydom, 2002: 72). The researcher's faith in the credibility of the study's findings must be echoed in the clear and unambiguous formulation and conveyance of research data. These findings should also be objectively relayed to the research participants without compromising the standard of confidentiality (Strydom, 2002: 72). Any possible shortcomings of the research endeavour's findings should also be clearly stipulated not only to determine the degree of generalisation of these findings but also to encourage the application of the results in other research projects (Strydom, 2002: 72).
- *Debriefing of research participants:* Strydom (2002: 73) suggests that research participants should be given the opportunity to process and reflect on their experience and its repercussions following the termination of the research process as a means of rounding off the study in an ethical manner. In addition to this, Strydom (2002: 72) also suggests a simply stated research report in order to assist the research participants to comprehend precisely what has been done with the information they provided. The debriefing session and research report should correct any possible misinterpretations that might have been conceived by the research participants and also address the termination and withdrawal of the therapeutic intervention in a sensitive manner (Strydom, 2002: 73).

3.7 IN CONCLUSION

This chapter concentrated on the features of the research procedure in order to provide a defining and comprehensive framework of the empirical segment of the research endeavour by explaining and advocating the mixed method research design in general and the convergent mixed method approach in particular. The chapter then proceeded to discuss procedures to be followed with regard to site selection, sampling, data collection and data analysis, in order to elaborate on the above-mentioned framework. Finally, the chapter relayed crucial ethical considerations which need to be taken into account during the empirical research process. The next chapter will proceed to render the findings of this empirical research process in more specificity.

CHAPTER 4

EMPIRICAL STUDY – FINDINGS AND DISCUSSIONS

4.1 INTRODUCTION

The research question for this particular study has been formulated as: How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision? This section communicates the outcomes and examination of empirical research conducted at a school for the visually impaired in Gauteng in an effort to answer above question.

As established in Chapter 3, this experiential investigation was conducted according to a transformative mixed method framework using a convergent parallel approach with the employment of a purposeful sampling method in order to amass information from persons with a particular extent of familiarity and understanding within a context which encompasses the very nature of Dance/Movement Therapy so as to enhance the expediency of the data collected. The methods that were employed to gather the information intended to address the diverging research sub-questions as stipulated in sections 1.5.2.1 and 3.2 included the engagement of the Rosenberg Self-Esteem Scale (RSES), the employment of a Dance/Movement Therapy programme, observation schedules, process notes noted in a researcher's diary, and participants' journal entries.

The empirical research process was initiated after having obtained the necessary consent and assent as stipulated in section 3.6. Participants completed the RSES to determine their levels of self-esteem prior to participation in a Dance/Movement Therapy (DMT) intervention programme. The six female adolescent participants then took part in eight 1 hour DMT sessions which were designed around possibly improving the degree of self-esteem in pubescent learners diagnosed with low vision. Upon completion of these sessions, each participant completed the RSES again as a post-intervention measure.

Quantitative results gathered from the pre- and post-intervention administration of the RSES were analysed by comparing each individual participant's pre- and post-intervention test scores (cf. Addenda O and P) in order to establish whether the participant's scores had increased, decreased or remained stable. This would indicate whether each participant's self-esteem had convalesced, diminished or remained unchanged. The researcher could also identify whether any of the participants' pre- and post-intervention scores had adjusted

to the degree that she progressed or regressed on the low, normal or high level of the self-esteem scale.

Qualitative data was collected through the use of observation schedules, process notes recorded in a researcher's diary, and participants keeping personal DMT Journey Journals. The observation schedules (cf. Addendum R) which the researcher completed for each participant after viewing each video-recorded DMT intervention session permitted comprehensive and illustrative documentation of each participant's movement, while process notes recorded in a researcher's diary (cf. Addendum T) served as an augmentation of the observation process by noting additional specifics about participants and their movement as well as the researcher's reflections with regard to the visual and auditory data recorded as the DMT intervention programme progressed. Both of these methods were employed to encourage a greater degree of objectivity during the data analysis and interpretation process. The inclusion of participants' DMT Journey Journals (cf. Addendum L for an example) allowed for the addition of participant reflection as well, in order for the researcher to compare each participant's contemplations with her RSES scores and observed movement.

The data collected through the above-mentioned qualitative strategies was analysed through first and second cycle coding. Descriptive and process coding were employed during the first cycle, while focused coding during the second cycle guided the researcher to refine the data gathered during the empirical research process (cf. Addenda V and W).

4.2 THE RESEARCH PROCESS

This section provides a brief account of the research process and the researcher's thoughts thereon.

As explained in section 4.1, the employment of an array of data collection strategies guarantees and authenticates the dependability of the information which was collected during the research process. Confidentiality agreements were signed by the Life Skills/Life Orientation educators and school psychologist who assisted in identifying learners who might have low self-esteem. The selected participants also signed confidentiality agreements to aid in keeping information shared during the 10 sessions secure (cf. Addenda M & N). Letters of consent were signed by the School Governing Body, the school principal and the selected participants' parents or legal guardians (cf. Addenda D, E & F). The participants also signed letters to indicate their given assent to participate (cf. Addendum G). The ten sessions, of which two were allocated to complete the RSES pre- and post-

intervention and the remaining eight consisting of the DMT intervention programme, were conducted in the school's hall over a period of 6 weeks.

4.2.1 Session 1 – Pre-intervention administration of the RSES

An A3 enlargement of the RSES was handed to each participant in a folder. They were instructed to write their names in pencil in the top right hand corner of the paper. Instructions with regard to its completion were explained by the researcher, who also explained that there were no incorrect answers. Although English is the participants' language of learning and teaching, it is not their home language and therefore the researcher also read through the questions with the group once and asked if there were any words that needed defining. The researcher had to clarify the following concepts: "qualities", "equal plane" and "inclined".

Before commencing with the completion of the questions, the participants were allowed to ask any clarifying questions. The participants wanted reassurance that they would not be judged for their answers. After reassuring them that indicating your feelings cannot be wrong, participants individually proceeded to complete the questions. All six participants tried to cover up their answers in some way, either by placing their hand or arm over the answers or placing their pencil case across the paper. After completion, participants turned their papers face down and replaced them in the folders. The completed questionnaires were then handed back to the researcher.

4.2.2 Session 2 – Creating connection and cohesion

This was the first DMT intervention session and it aimed to substantiate group interrelations and affinity by introducing each participant and identifying a group name through collective movement. Participants displayed behaviour such as giggling, fidgeting and looking around which suggested that they felt nervous and unsure of themselves. They were handed their personal DMT Journey Journals and the researcher explained how the check-in section of the journal prior to the commencement of each session worked. The participants asked many questions to ensure that they did not make any mistakes.

During the compilation of the code of conduct (cf. Addendum Q), the participants' contributions all centred on protecting their feelings and therefore also their self-esteem. The researcher had to add organisational aspects such as punctuality and appropriate attire. With regard to the stimulus, no one wanted to look in the mirror first and when they finally did look at themselves in the mirror after the researcher had initiated the process by going first, their actions were very self-conscious, like walking away from the group while looking into

the mirror or covering their faces with their hands. All participants' range of improvised and structured movements was small and executed close to their bodies, but as the structured movement sequence was repeated, some participants' movements became stronger and more defined.

After the collaborative movement section, the group decided on the name "Starlight Mix" for their group name. "Starlight" was based on the fact that they considered their "brightness" to be far away and out of reach, and because they felt that no one gets close enough to them to see how they can really shine. This echoed the psychosocial challenges individuals with low vision experience as was depicted in Chapter 2, Section 2.4.2. "Mix" was added to the name because they all felt, looked, thought and moved differently. During the reflection process participants took on a more relaxed body posture and style of language.

4.2.3 Session 3 – Words shape me

The goal of this session was to express through movement how negative verbal feedback makes each participant feel, and to interchange the expressed negative feedback with positive feedback from other group members through movement.

Participants seemed more at ease, but when they received their DTM Journey Journals, they enquired of the researcher whether she had read their reflections from the previous session and whether they had done the reflections correctly, which suggested not only a fear of failure but also a need for approval. The participants also wanted to know whether the group name and code of conduct were going to remain on the wall or whether the researcher was going to take it down after each session, which suggested to the researcher how vulnerable the participants felt at that particular moment.

When the participants had to sign the code of conduct, the majority of them did not have signatures. The researcher suggested that they simply write their initials and surnames in capital letters, but could not help wondering whether having a signature contributes to identity formation and whether not having a signature yet might be an indicator or result of low self-esteem.

Participants were excited to show that they had started a Whatsapp group for Starlight Mix members and wanted the researcher's opinion on which of four profile pictures, designed by themselves, they should choose. During the movement section there was noticeably less looking around and movements generally seemed more controlled and coordinated. When the participants had to write down the most hurtful negative feedback they had received, they still tried to cover up what they wrote, but they were more willing to share their feelings

about this feedback through movement. They were very surprised when reading the positive feedback their group members communicated to them through writing.

The movements expressing their feelings about the negative feedback were still kept close to the body centre, but when the participants expressed their feelings about the positive feedback, their movements seemed more open and definite. This reflected the relationship between emotion and motion as was explained in Section 2.7.1. During the group movement sequence, the participants' movements had more definition and extension. The reflection process happened more independently and participants seemed more relaxed and trusting towards each other.

4.2.4 Session 4 – Feeling feelings

The purpose of this session was to explore what experiencing failure and success feels like through tactile stimuli, and subsequently to render abstract emotions as concrete representations by expressing feelings linked to failure and success through movements which mirror the described tactile stimulus.

While handing out the journals the researcher reminded the participants that their feelings and thoughts were not judged as right or wrong and that their opinions mattered. The researcher also complimented the participants on how their reflection skills had developed between the second and third sessions. The researcher further focused the participants' attention on the fact that the group name and code of conduct had been taken down after the previous session. All of this was done in an effort to ensure the accepting and ability-promoting environment which effective DMT calls for, as was stipulated in Chapters 1, Section 1.3.3.1 and 2, Section 2.7.

A few of the group members were sick with the flu and one member was absent due to tonsillitis. This made the researcher consider how physical health might affect the participants' current level of self-esteem. It also led the researcher to adjust the warm-up exercises for those particular participants to consist only of light stretches to ensure that the session was not too strenuous. The researcher did however add an additional aerobic and a strengthening exercise to the warm-up for those who were not affected, to challenge them, as it was clear that they had become familiar and comfortable with the current warm-up routine. The researcher wanted to create opportunities for the participants to be challenged and subsequently transcend what they initially thought they could not do so that they would have significant opportunities to experience success as was proposed in Chapter 2, Section 2.5.

Participants mentioned how they always struggled to describe how they felt or understand the emotions of others because they couldn't always see the person's facial expression. They noted that by comparing something you cannot see to a tangible texture that everyone is acquainted with, and which they could access at the same level as everyone else, made it easier to explain and comprehend sentiments. They were very excited to share this skill with their blind peers. Because one participant was absent, the researcher had to stand in when the group was divided into two groups of three. This made facilitation a challenge and made the researcher consider the possibility of including another facilitator within a purely therapeutic setting.

One participant had distanced herself from the rest of the group and ceased to participate. She explained that she felt inferior to some of the other participants as she was the youngest. The researcher conceded that being the youngest in a group might cause the individual to feel less experienced and less competent. Another participant noticed the researcher talking to her and tried to comfort and include her. This made the researcher consider increasing the homogeneity of a DMT group even further to include participants who are not only in the same developmental phase but who are also of the same age.

The movements created by the participants were surprisingly original. The improvised movements expressing feelings of failure were contracted and hunched, while movements representing feelings of success were elongated and more open. The intervening movements that participants had to create for each other spoke of support and encouragement and included bigger, more sweeping movements

4.2.5 Session 5 – Rolling with role models

In the next session, the intention was to acquaint participants with possible role models with low vision, identify personal traits or experiences of role models with which participants could identify, and express which traits participants aspired to for themselves.

Three participants were absent due to the flu. The three participants who were present seemed more at ease, spontaneous and willing to share. The participant who had felt inferior to other participants indicated that she felt more accepted and at ease. This made the researcher consider that a smaller group limited to three or four participants might increase the usefulness of the DMT intervention. Participants were surprised to hear about famous individuals who have also been diagnosed with low vision, which aligned with

existing literature as was discussed in Section 2.4.2.1, regarding a lack of visually impaired role models.

They all associated with the South African example, while their second choice of role model was based on shared interests in either, singing, dancing, writing or acting. This made the researcher realise the importance of relevancy when it comes to presenting the participants with role models and made the researcher consider the inclusion of successful individuals with low vision who either work at the particular institution or who matriculated from this particular school.

The participants seemed more eager and willing to share the movements they created for their fellow participants – possibly because it was not the sharing of their own personal feelings but rather the chance to mean something to someone else by making a worthwhile and acknowledged contribution to their well-being – a need which was identified as determinant of transcendence in Sections 2.5 and 2.6.1. The researcher noted that the participants' movements were starting to expand – moving away from the centre body and utilising more space. The participants' reflections were more detailed, in-depth and personal, which might be due to the smaller number of group members for this particular session.

4.2.6 Session 6 – Personal progress patterns

The objective of this particular session was to identify a personal weakness as well as a personal strength of each participant, to determine how to employ the identified strength to overcome or work on improving the mentioned weakness. Participants would then express this process of personal progress towards self-acceptance through movement by drawing movement patterns on A3 paper which would ultimately represent their first piece of choreography.

The researcher pointed out that the intervention programme was half way through and wanted to know how the participants felt at this point. Comments included that they felt closer as a group, that they had felt "torn" at the commencement of the programme but that they were starting to "heal", that they were learning how to "trust the truth in people's positive words, while learning how to let go of people's hurtful words" and that they were scared and unsure when the programme started, but that they were believing more in themselves every day. They also enquired as to whether the programme would continue for other learners of the school and whether they could come and assist the researcher by providing guidance to those learners.

The researcher added more new sequences to the warm-up regime to challenge the participants. They enjoyed the aerobic exercise, but complained a bit when the strengthening exercise started to work their muscles. They were however very impressed with themselves after showing determination and finishing the exercise – some expressed out loud that they didn't think they could make it.

When instructed to think of a personal weakness and a personal strength, the participants exclaimed that they had learned about strengths and weaknesses in Personal and Social Well-being (PSW) as part of the subject Life Skills. This made the researcher contemplate whether the content of the three study components of Life Skills, i.e. Physical Education, Personal and Social Well-being and Creative Art, could be synchronised at some stage during the curriculum to include the 4-week DMT intervention programme as part of the curriculum, as the employment of all three areas was proposed to encourage physical, psychological and social development in Chapter 1, Section 1.3.3.1.

Some participants' entire choreography was drawn on one side in the top corner of the page. Those particular participants' movements correlated with what they created on paper: small, narrow movements while staying more or less in one place. Other participants used the whole A3 page and their engagement with space as well as their range of movement was similarly depicted. Reflection was done independently and with greater confidence. The same applied to the curtsey at the end of the session.

4.2.7 Session 7 – Holding back or helping

Session 7 aspired firstly to identify and explore thoughts and emotions associated with feeling dependant on others through a group movement activity, then to identify and explore thoughts and emotions associated with being supported to be independent through a group movement sequence, and finally to highlight the importance of communication and facilitate an increased understanding of how the above situations affect self-esteem and social relationships.

The researcher documented that the participants were sharing more willingly during the check-in section of the session. After the previous session the participants combined each participant's pattern movement sequence to choreograph their own movement piece. This suggested to the researcher that the participants had gained confidence in moving independently without facilitation, that they had discovered meaning in the knowledge and skills they had learned thus far and that they were able to apply the former and the latter

outside the DMT intervention programme. The participants were quite upset that one participant was absent again. They were concerned that she was not going to benefit as much from the programme as they were, which suggested to the researcher the extent to which group cohesion had developed.

During the improvised movement section where participants had to move against the restraints of two other participants, their facial expressions clearly indicated feelings of frustration. After the stimulus the researcher asked the participants how people treat them because of their low vision. Their answers included that people think they cannot do anything for themselves; that people are scared that they might get hurt if they are not with them all of the time; that people want to do everything for them and that people say their future will be limited because they won't be able to drive to work. The researcher then enquired of the participants how they felt about the mentioned comments and actions. They answered that they felt similar to how they felt during the improvised movement – that they felt "stuck"; that it felt as if they were carrying everyone else with them and it made them feel just as heavy as they had felt during the improvised movement; that they felt frustrated in the same way as they felt when they had to execute the movements against restraints.

After executing the structured movement sequence in which participants had to tell the other group members what they would like them to do so that they could support their movements, the researcher enquired of the participants how they felt this time around. Comments included how they felt more able to move; that they didn't feel like they were being held back; that they had more freedom but at the same time felt more in control; that they felt as if they could do what they wanted, but knew the other participants were there for them; that they felt they could be more daring because the needed support was there; and that they didn't get tired as quickly and could execute their movements better.

Lastly, the researcher asked how this related to the manner in which they would prefer to be treated regardless of their low vision. The participants answered that they wanted to be allowed to make their own mistakes so they that they could learn from them, while knowing that if they failed, they would still have the support they needed. One participant equalled it to running the 1500-meter item at an athletics meet: she knows she can run on her own, but she gains stamina and determination from the people who are cheering her on. Other participants said they felt more willing to take risks, to chase their dreams, with the knowledge that they were being supported. The above-mentioned comments from the participants correlated with research findings which were discussed in Chapters 1, Section 1.3.3.1 and 2, Sections 2.4.2.1 and 2.4.2.2.

The researcher further deliberated on the fact that it is human nature to want to help someone who is not as able at something as you are. From personal experience, the researcher knows that every teacher starts teaching at this institution with the feeling that he/she is sorry for the learners and wants to do everything for them – until they realise how adept most of them are. But if teachers feel this way, how much stronger must this feeling be for a parent or close family member and how must a community member who only sees the person from afar come to the realisation that they are able? This is not even taking into account the cultural and religious stigmas which are involved in South Africa's frame of reference as discussed in Section 2.4.2.2. In the researcher's opinion, this is a very relevant and serious issue which should be addressed through family and community psychology.

Since one participant was absent again, the researcher had to take part in the improvised and structured movement sequences and could not facilitate the session to the degree she would have liked to. There were times when the participants were playing around, but luckily while doing so they were experimenting with spontaneous movement which made the researcher realise how much they had progressed in their confidence levels when it came to movement. The researcher still feels however that a second facilitator who could step in when absolutely necessary would be a good consideration for the physical safety of the participants as an injury could easily occur without focused supervision.

The researcher noted that reflection now happened naturally and independently and that a few participants were finally willing to share their reflections with the group. One group member did not like to be touched or to have others come into her personal space, which made the researcher consider the use of props such as ribbons and hoops to represent restraint in future to accommodate this personality preference.

4.2.8 Session 8 – From small to tall

This session planned to encourage the exploration and use of space and levels, to consolidate content and experiences from previous sessions in preparation for the final or termination session, to reflect on each participant's DMT journey thus far, and also to express and share thoughts and feelings through the movement method of story-telling.

Two participants mentioned that it was a stressful time for them as they were completing third term assessments and that they had started doing the cool-down stretches and breathing exercises at night before bath time which made them feel more relaxed and able to study. This suggested to the researcher once again that they were independently

applying the skills they were being exposed to during the DMT sessions. Some of the participants asked the researcher to explain higher order words such as “confined”, spacious”, “cramped”, “expanded” and “contracted”. The improvised movements which they created did not only speak of understanding but also of originality and were more expanded, elongated and open in general. All the participants used more space and varied the level of their movements more than in previous sessions.

Some participants were however more comfortable with employing space and levels than others were. This could also have to do with the range of movement with which their bodies felt comfortable. Those whom the researcher had observed to be more agile when doing warm-up and cool-down exercises did seem more comfortable with reaching out into space, enlarging their movements and moving between lower and higher planes. On the whole, all of the structured movement sequences spoke of release, of liberation. The participants found the idea of removing the “dis-” from “disability” very significant. They had never conceived that when this prefix is removed, all that remains is “ability”.

The participants enquired as to whether they could keep the structured movement piece which they had created on paper because it would remind them of how far they had come and how much they had grown. This signified to the researcher that there was still a need for validation and a possible fear of regressing to previous levels of self-esteem when leaving the accepting environment of the DMT group.

The importance of observing every participant individually during every session from start to finish, as existing literature proposed in Chapter 2, Section 2.7.1, was emphasised during this session as physical ability and personal progress had to be considered when evaluating the structured movement sequences. The researcher considered the recording of such sessions to be invaluable for this very reason as it allowed the facilitator to go back, compare and pick up small details which might have been missed originally. This enabled the researcher to see that all participants had made progress in trusting the space around them, while when looking at this session in isolation, it might have seemed as if some participants had not made any gains at all.

4.2.9 Session 9 – A salute to self-worth

Session 9 aspired to affirm self-worth through reading a poem about self-worth and creating a movement piece to go with the poem, to celebrate each participant for what she had contributed to the programme, and to consolidate and terminate the programme.

The participants noted that it was very sad that the group name and code of conduct were being displayed for the last time. One participant mentioned that she wished they could take the code of conduct out into real life. The other participants agreed that it made them feel safe. The researcher explained that they must take an inside-out approach towards the code of conduct: they could take the code of conduct out into the real world by applying it in their interactions with others and feeling good about themselves for treating people in an exceptional way.

The participants noticed how each session built on the previous ones and mentioned that by summarising the programme they could realise how much they had mastered and how they had conquered the uncertainty and nervousness they had felt at the commencement of the programme. The researcher acknowledged their comments by highlighting how much strength and courage it took to overcome those fears and to master each instruction presented to them. Participants pointed out how the poem "*I love being me*" (cf. Addendum K as included in the DMT intervention programme) reiterated everything they were thinking and feeling, when going out into society. The individual movement sequences that transpired from each stanza attested to personal revelation: sweeping, releasing, big and open movements – not to mention the innovative nature thereof.

When the participants put their individual improvised movement sequences together, they created an awe-inspiring movement piece which was expressive enough to convey their message without using words, and also performance-worthy. It was clear that they were really proud of what they had created. Reading the poem while they executed the movement piece was truly a goose-bump moment and as they repeated it and gained confidence in what they were doing, their movements became even stronger and more defined. They asked to do it to music, but as their movement was based on the rhythm of a poem, they struggled to make the counts work. The researcher noticed frustration was building up and intervened by explaining that they were more than capable of doing the piece in time to the music, but that adapting the moves and counts to fit the music and then synchronising the movements is something that does not happens in 15 minutes, which was the time allocated for this section of the session. The researcher explained to them that this was where the difference between movement and performance comes in: movement is expressive and spontaneous while performance takes hours, weeks and even months of practice. The researcher then suggested that the music be played in the background, while she read the poem and they executed the movement sequence. This ensured that the participants still ended off the session with an experience of success.

The participants wanted to know why the researcher chose the words she wrote on each of their respective certificates. The researcher referred to the instances when she noticed the specific characteristics that each participant embodied. This made the researcher think about how low their initial levels of self-esteem had been as they clearly considered positive feedback to be in contrast with what they thought about themselves. The participants then asked if they could say what they would write on the researcher's certificate. This initiative highlighted once again the participants' need to contribute constructively to the lives of those they come into contact with.

The free movement session was very liberating for each participant. *Pantsula* movements, which is a highly energetic dance form which originated in the South African townships, were especially prominent. The researcher noted that normative African dance movements such as *Pantsula* never featured during the other sessions, which made her wonder about its expressive potential which might still be unearthed. After executing the curtsey and vocalising the meaning thereof (i.e. "I thank you and I acknowledge you"), the group spontaneously gathered for a group hug which confirmed the extent to which group cohesion had been established.

The researcher was astounded at how the participants had gained confidence over the past four weeks, but realised that they only felt this way inside the accepting and ability-promoting space of the group and were still not sure about whether they would be able to handle the outside world's uninformed and unprepared thoughts, behaviour and infrastructure. The increase in self-esteem and subsequent psychosocial well-being which is hoped for would be a sweet victory, but she realised there is so much more to be done in terms of family and community education and transformation, as had been suggested in Chapter 2, Sections 2.4.2.1 and 2.4.2.2.

4.2.10 Session 10 – Post-intervention administration of the RSES

The RSES was completed again post-intervention. The questionnaire was once again enlarged to A3, placed in a folder and presented to each of the six participants to complete individually. They wrote their names in pencil in the top right hand corner of the paper. The researcher relayed the instructions pertaining to the completion of the RSES to the participants and again emphasised that there were no incorrect answers. She read through the questions out loud and made sure that she clarified the words that they had been unsure about during the previous administration. Before commencing the final completion of the questions, the participants were allowed to ask any clarifying questions, but they indicated that they did not have the need to do so. This time around the participants were not

concerned about their answers being judged, the atmosphere was much calmer and they did not attempt to cover up their answers. Once the RSES was completed the participants turned their papers face down and returned them in their folders to the researcher.

4.3 DATA ANALYSIS

4.3.1 Analysis of quantitative data

The RSES was administered and scored in accordance with the manual before the Dance/Movement Therapy intervention sessions were implemented, as well as after the programme was concluded. The RSES indicates that scores between 15 and 25 denote a normal level of self-esteem, while scores from 15 and lower point toward low self-esteem. Bearing in mind that the sample size is too limited to determine any degree of generalisation of the results obtained through the administration of the RSES, each respective participant's pre- and post-test scores were weighed against one another to establish only whether the particular participant's level of self-esteem had increased, remained the same or deteriorated. It was also determined whether any of the participants' pre- and post-test scores had transformed to the extent that she moved from the low self-esteem range to a normal scope of self-esteem or vice versa. Below are the details of the analysis:

Participant	Pre-intervention score	Range of self-esteem	Post-intervention score	Range of self-esteem	Did participant's self-esteem adjust to a different range on the self-esteem scale?
A	14	Low	18	Normal	Yes
B	13	Low	16	Normal	Yes
C	15	Normal	16	Normal	No
D	10	Low	19	Normal	Yes
E	11	Low	14	Low	No
F	10	Low	13	Low	No

Table 4.1 Analysis of participants' pre- and post-intervention RSES scores

A graphic representation of each participant's pre- and post-intervention results is presented below:

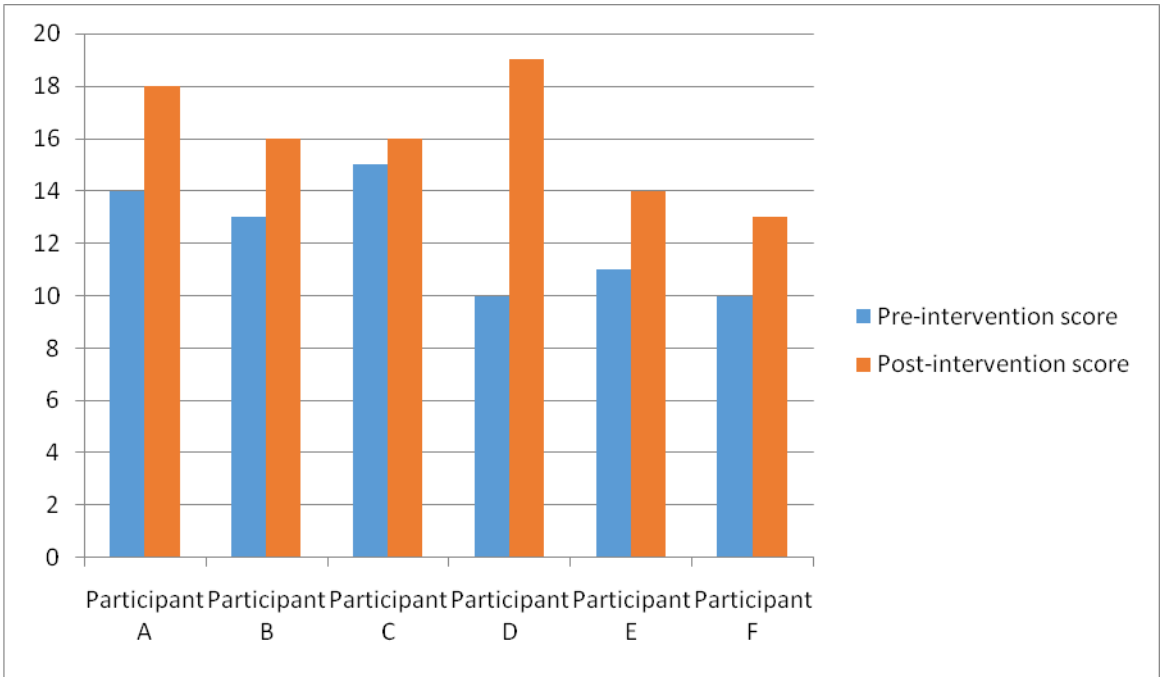


Figure 4.1 A graphic representation of each participant's pre- and post-intervention results

4.3.2 Analysis of qualitative data

The following data collection process was employed to formulate conceptualisations with regard to the qualitative data gathered through the observation schedules, process notes in a researcher's diary as well as the participants' personal DMT Journey Journals:

- The researcher designed an electronic document in Microsoft Word consisting of a table with four columns which respectively specified the data collection procedure, the significant data extract, word or clause encapsulating the data segment, colour coded words or phrases which indicated possible codes and finally codes which reiterate or intersect one another (cf. Addendum V).
- The researcher then studied each separate data collection set and highlighted relevant extracts manually to determine noteworthy data components and made summaries of each data collection set's significant information so as to assist with the completion of the coding table and to ensure that no relevant information had been overlooked (cf. Addenda S and U).
- The data collection procedure was entered into the first column.
- The identified data excerpt was then allocated to the second column.

- Words or phrases reflecting relevant resemblances, distinctions, regularities, cycles, correlations or causativeness were then highlighted in the second column with various distinctive colours.
- These colour coded words or phrases were then transferred to the third column.
- The colour coded words or clauses assisted in identifying repeating or interrelated codes which were then indicated in the final column.
- The researcher then used the fourth column to compile a list of key codes, significant codes and remaining codes which are indicated in Addendum W.

The researcher then studied the listed codes to create categories from the essential and focal codes. The principal categories or patterns were then utilised to devise a theoretical framework within which findings could be ordered, elaborated upon and comprehended. Sections 4.3.2.1 through 4.3.2.6 outline the final step of data analysis and contain advantageous information to address the research sub-questions which were proposed in Section 3.2.

4.3.2.1 Theme 1: Indications of low self-esteem prior to and during the DMT intervention programme

Signifying factors of the low levels of self-esteem with which participants undertook this intervention programme may be summarised as insecurity and uncertainty. As noted in Section 4.2.1, participants displayed behaviour characteristic of the above through excessive giggling, continuously looking around, and trying to cover the answers they had entered on the RSES.

All participants' observed movements, as recorded on their respective observation schedules, were restricted, limited and executed close to the body centre during the warm-up, improvised and structured movements, as well as during the cool-down sections of the first DMT intervention session and although their movements developed more control in terms of the warm-up and cool-down sessions, their improvised and structured movements remained bounded to varying extents until Sessions 5 and 6. An uncertainty about the space around them was also notable as their use of space only showed significant progression from Session 7 onwards. Self-soothing patterns of movement such as hugging themselves, rocking back and forth or swaying from side to side were also exhibited in initial sessions.

The researcher noted the above in her process notes as well and, in addition, recorded that the participants were initially afraid of making mistakes during their reflections and had wanted the researcher's approval of the reflections' content. It was also recorded that the

participants constructed the code of conduct around attempts to prevent their self-esteem being negatively affected even further. The extent to which the participants were feeling vulnerable was also clear when they enquired whether the group name and code of conduct would remain displayed between sessions or be removed and returned during each respective assembly of the DMT group. The researcher also noted that movements representing aspects that negatively influence self-esteem, such as negative feedback or feelings of failure, were mainly small and contracted in nature and executed with a hunched posture. Participant reflections in their personal DMT Journey Journals also indicated that they felt nervous and uncertain during the first and second DMT session and that they needed to gain confidence and also to trust themselves and other group members more.

4.3.2.1.1 How does this relate to psychosocial well-being?

From observations made during the pre-intervention administration of the RSES, the participants exhibit their feelings of insecurity and uncertainty in everyday social settings and in their interactions with others. In this case the researcher was aware of the reason behind their behaviour and could provide reassuring and constructive feedback, but in other, less controlled situations, uninformed feedback would contribute to and even exacerbate current feelings of insecurity and uncertainty as explained in Chapter 2 section 2.4.2.

As noted from the observation schedules as well as from the process notes from the researcher's diary, the participants also felt uncertain about the space around them, which inadvertently affects the way they engage with their micro and macro systems on a daily basis. This does not only increase the chance of receiving negative or deconstructive feedback from uninformed individuals, which then adds to their already low self-esteem, but also keeps them from venturing out into the world, acting independently and experiencing success. Extended micro and macro systems, independent behaviour and experiencing success have been proven to contribute to a person with low vision's self-esteem, as explained in Chapter 2 section 2.4.2.1 and 2.4.2.2.

Should the participants exhibit similar behaviour in every day interchanges to those they exhibited when compiling the code of conduct, i.e. attempting to protect themselves from further hurtful or negative feedback which further breaks down their self-esteem, it would suggest that they limit their interactions to the few individuals they trust and limit their behaviour to that which they know they can do successfully, thus robbing themselves from possibly enriching experiences and opportunities for learning and personal growth.

Physical aspects such as poor posture and limited movement has also been proven to determine body image (section 2.4.2.3), which is a significant aspect of self-esteem and the manner in which the participants present themselves to the outside world. This unavoidably

impacts on their social exchanges which in turn, depending on the nature of the social feedback, impinges on their level of self-esteem. Finally, it was clear from the excerpts taken from the participants' personal DMT Journey Journals that events, actions and words involving or directed at them attributed to their current low levels of self-esteem.

The above finds resonance in the next theme to be discussed in the section to follow.

4.3.2.2 Theme 2: The significant role of the micro and macro systems on self-esteem

The relevant literature studied and conveyed in Chapters 1 and 2 suggests that a person with low vision's immediate and extended family and his/her wider social system are irrefutably connected and consequently determinant of his/her self-esteem and therefore also the level of his or her psychosocial functioning (sections 2.4.2.1 and 2.4.2.2).

The observation schedules of each respective participant indicated that restricted range and bounded or limp quality of movement as well as the quick and sudden execution thereof were characteristic of movement sequences where the participants had to express their feelings about negative or hurtful feedback from significant figures in their broader social systems or experiences of failure within these environments. When studying the process notes in the researcher's diary, this notion was also reiterated. The choice of the group name was partially based on the participants' feeling that no one was informed about their diagnoses of low vision to the extent that they could comprehend what they were capable of as well as their conviction that, should they be given the same opportunities as individuals with normal vision, they would be able to prove that they were just as able as their sighted counterparts. The participants' distrust of others outside of the DMT intervention group was also suggested when they compiled the code of conduct and also when they were concerned about whether the said code of conduct and the group name would remain displayed on the wall of the hall between respective sessions.

During Session 4, they expressed how challenging it was not only to explain what they were feeling to others, but moreover to comprehend what others were feeling as they were seldom able to see finer details conveyed in facial expressions and more subtle gestures of body language, which reflected content discussed in Chapter 2, Section 2.4.2. The participants' astonished reaction to learning about role models who have transcended their diagnoses of low vision to achieve success in various fields of the career world, not only highlighted the significant impact of the macro system on the participants' self-esteem but also magnified the degree to which this very system lacks in promoting, understanding and subsequently including the abilities of individuals with low vision. The fact that all participants also related more to the South African role model further suggested the degree to which their macro system forms part of their identity and consequently their self-esteem.

The researcher also mentioned in her process notes that the participants indicated their need to feel that their contribution to this wider social system was not only needed but also valued. The researcher's process notes for Session 6 also noted that participants stated that they were learning to trust the positive feedback and simultaneously let go of negative comments made by people in their immediate as well as wider social circles. Session 7's process notes were especially significant in this regard as the participants equated the improvised stimulus and subsequent movement sequence with how their immediate and even extended social systems treat them because of their low vision, as well as with how it made them feel trapped, burdened and frustrated. The potential of these systems to enable and empower the participants was also made clear after they completed the structured movement sequence and commented on how they simultaneously felt more freedom and control, safe but also more willing to take risks and more capable when they knew they had support.

During Session 8 the researcher documented that the participants wanted to keep the visual representation of their structured movement piece to remind them how far they had come and how this might suggest that they were afraid of regressing to their previous levels of self-esteem when they left the safety of the DMT group. This premise was substantiated in Session 9's process notes which indicated that participants wished that they could take the code of conduct out into their close and extended social systems because it gave them a sense of security. The researcher also reported that the participants felt that the poem "I love being me", which served as a stimulus for their improvised and structured movement sequences, held specific relevance to how they felt when they ventured out into society. With regard to the participants' reflections in their personal DMT Journey Journals, each check-in section, which was completed at the commencement of every respective DMT session, indicated that the participants' self-esteem might fluctuate slightly depending on significant events or interactions which occurred during the day.

4.3.2.2.1 How does this relate to psychosocial well-being?

When considering the restricted nature of the participants' movements as observed on their respective observation schedules as well as in the process notes in the researcher's diary noting the participants' disappointment in and distrust of their immediate and wider social system, it is clear that their personal actions and social interactions have been tainted by the unconstructive and insensitive views and responses of their immediate and wider social systems.

The intense feelings expressed through their movement sequences relating to their experience of failure are not just rooted in a personal sense of disappointment, but also in

the reaction of the micro and macro systems that equate their failure to their diagnoses of low vision. Whereas an individual with a normal range of sight would be excused for being human or in the process of learning, society determines that the person with low vision's failure is indicative of their disability. Therefore, the participants have formed an established correlation between their low vision and their low self-esteem and this in return informs the way in which they approach the challenges which everyday life presents.

The relevant observation schedules, process notes and reflections from the participants' personal DMT Journey Journals also indicate how the participants' micro and macro systems do not grant them the opportunity to act independently and prove themselves to be just as capable as their counterparts with a normal range of sight. As also stated in section 4.3.2.1.2, this robs them of the chance to experience success and personal growth, which inhibits their self-esteem. They are also not then able to experience the boost in self-esteem which stems from making an acknowledged and valued contribution to society. Moreover, their low self-esteem is observable in their social exchanges and, in a vicious circle, then confirms their immediate and wider social systems' preconceived notions with regard to their impaired ability.

As referenced academic literature in Chapter 2 (sections 2.4.2.1 and 2.4.2.2) stipulates, participants find it difficult to identify and understand the facial expressions of the people in their micro and macro systems and this leads to uncertain or even inappropriate reactions within social settings. The feedback this incurs then inadvertently has an impact on their self-esteem, which again in a cyclic fashion, influences the degree of confidence with which they are able to engage with the world.

Furthermore, the mere fact that role models who have transcended their low vision to achieve success in their personal and vocational spheres are under-represented in society, has an influence on the self-esteem of younger individuals with a similar diagnosis as they cannot assimilate this as part of their identity formation. This then directs the extent and quality of their social interactions and, as stated before, their subsequent cautious and uncertain actions towards and interchanges with their immediate and wider social systems support these systems' misconceptions about the degree of their ability.

The aforementioned contributions to low self-esteem however also suggest that the person with low vision's micro and macro systems hold the power to contribute to the improvement in their self-esteem if the deeply rooted preconceptions with regard to their ability can be altered, and encouragement as well as support can replace current limitations and restraints imposed on such individuals. The opportunities for acting independently, experiencing success and personal growth as well as making a recognised contribution to their close and

extended social circles would improve their degree of self-esteem and subsequently enhance their level of psychosocial welfare.

Finally, the fact that daily happenings within and interactions with the participants' micro and macro systems are determinant of how they feel about themselves on that particular day, is a significant acknowledgement as it establishes that self-esteem might fluctuate from day to day, but can also present the person with low vision with much needed perspective by offering the realisation that their low self-esteem is not purely based on their low vision. This can break the cycle of negative feedback and subsequent negative interactions between the person with low vision and his/her social systems, which will then have a positive result on their psychological as well as social state.

The recurring connection between psychological and social aspects is a precursor to the following theme which will be analysed in the section below.

4.3.2.3 Theme 3: The relevance of conducting this particular DMT intervention programme in a group format

This particular theme begins to address the research sub-question which was posed in Section 3.2 pertaining to how an accepting environment which promotes ability will be established. When considering denotations made from the participants' respective observation schedules, the process notes surmised in the researcher's diary as well as the reflections written by the participants in their personal DMT Journey Journals, it seems that the mentioned accommodating and ability-promoting environment had been established through taking a group approach to this specific Dance/Movement Therapy intervention programme to a significant extent.

Observation schedules of Sessions 2, 3 and 9 indicated that the participants' movements were executed with greater confidence, direction and definition when executing the structured movement sequences which required the collaboration and collective execution of their individual improvised movement sequences. It was also noted that the linking movements which participants created for each other in pairs during Session 4 were more distinct and sustained, and that they made use of the space around them. Although it was not part of the sixth session, the participants used some of their social time after the session to combine their structured progressive pattern movement sequences from Session 6 to create another joint movement piece. During Session 7, participants' movements were noted to be more controlled, defined, extended and even in some cases daring when they were supported by two other participants.

With regard to the process notes recorded in the researcher's diary, the researcher noted as early as the first DMT session that participants seemed more confident when executing their movements as a group. It was also documented that a sense of camaraderie had already been established with the decision on a representative group name, as they all acknowledged that they were different from persons with a normal spectrum of vision and furthermore that they were not being presented with opportunities to prove their unique capabilities. The researcher's process notes on Session 3 also reflected that participants exhibited their most defined and extended movements when performing their respective structured movement sequences as a unified group movement piece. The researcher further wrote that the participants' interactions with their fellow group members seemed more relaxed and trusting which contributed to a greater impression of security among the participants due to a developing sense of group cohesion.

The temporary and slight break in the group's developmental consistency with regard to cohesion was marked by the researcher in Session 4's process notes. Although all six participants were classified as adolescents, some group members were older by one or two years than other participants and the youngest participant felt less experienced and less competent compared to her older peers. This led to the participant stating that she did not feel part of or positive about this group and caused her to cease her participation in the session. Other participants noticed her retraction from the group and made directed efforts to make her feel included and needed. This situation not only confirms the significant role which social interactions play in determining self-esteem but is also key to promoting or abolishing the accepting and ability-promoting environment which effective DMT intervention calls for due to its powerful impact on the psychological and social.

Session five provided even more supporting notations, as reflected in the researcher's diary, which specifically pertained to how a smaller group of only three participants enhanced the degree of sanctuary and acceptance. This notion is supported by further process note entries which state that participants acted more spontaneously, were more willing to share their thoughts and feelings, and displayed more relaxed interactions amongst themselves. The researcher also noted in all eight sessions that there was a connection between increasing group cohesion and developing self-esteem.

When studying the participants' reflections in the personal DMT Journey Journals, contemplations about how the encouragement from and support of their peers were contributing to their improved sense of self-worth were consistently made across all eight sessions. Deliberations about how good it felt to provide encouragement and support to others were also noted throughout. Thus it seems that participants' self-esteem did not just

benefit from the sense of acceptance provided by the group but also from the establishment thereof.

It is important to mention that the observation schedules, the researcher's process notes and the participants' reflections indicated a progression in the role of the group as it shifted from participants being dependent on the group for security to the participants drawing from it as a source of support when needed.

4.3.2.3.1 How does this relate to psychosocial well-being?

With regard to psychological well-being, the group DMT setting gave participants the chance to work on their self-esteem without the focus being solely on individuals during the initial sessions. Therefore, the social element added to the DMT intervention programme by implementing it in a group gave them the option to "hide" within the group until they felt ready to venture from its safety. The group also encouraged the application of the expressive movement skills which were gained during the DMT sessions outside of the intervention programme, which inadvertently contributed to each participant's self-esteem and subsequent psychological well-being by experiencing success outside of the programme.

The sense of feeling part of something and taking responsibility for each other, i.e. having a sense of social responsibility, also added to feelings of self-worth which improved self-esteem and psychological well-being. Finally, being able to associate with their group members in regard to their thoughts, emotions and social experiences, made them feel less isolated and more understood, which also contributed to a greater sense of psychological welfare.

When considering the implications for social well-being, the conduction of the DMT sessions in a group format is especially noteworthy when bearing in mind that the majority of the participants' social interactions and experiences prior to taking part in the intervention programme were uncertain or even negative and debilitating in nature. Conducting the sessions in a group created a space where more positive interactions could be simulated and participants' perceptions could be adjusted, thus supplementing their sense of social well-being. Various sections in this study have also referred to the fact that participants are not granted many opportunities to make contributions to their social systems. The fact that the group compilation allowed them this opportunity through encouraging and supporting each other gave them a sense of being valued by others and presented them with experiences of positive social interactions which inadvertently contributed to their social welfare. Finally, the established group cohesion and subsequent accepting and ability-promoting environment further added to a greater sense of social well-being.

4.3.2.4 Theme 4: Indications of improvement in self-esteem during and at the end of the DMT intervention programme

An improvement in the participants' self-esteem has already been hinted at in the previous three themes, but this following section will focus specifically on commencing to answer the research sub-question posed in Section 3.2: How did the Dance/Movement Therapy intervention programme influence the participants' self-esteem and subsequent psychosocial well-being? As mentioned in Section 4.3.2.1, the observation schedules of each respective participant noted restricted, contracted and slight movements during the first DMT session. From there on, each participant's movements showed development in various degrees with regard to progression in the range and quality of their movement pertaining to size, shape, execution and employment of space as they were provided with opportunities to transcend challenges, experience success and subsequently gain confidence in the execution of and reflection on their movement sequences as well as in their interactions with each other.

The researcher also observed that the participants' movements became stronger, more defined, elongated and encompassing when movement sequences required repetition and they felt increasingly capable with each execution. Finally, the observation schedules also indicate how the aforementioned progression in the range and quality of their movements was initially only detectable in their structured movement sequences, which by nature is more planned and predictable, but that later on, this was extended to reflect even in their improvised movement sections. The association between feeling more capable and confident and exhibiting more definite, stronger and larger movements therefore suggests an improvement in self-esteem.

Process notes in the researcher's diary also drew a parallel between more fervent, distinctive and copious movements and an enhancement in self-confidence. More specifically, process notes for the first two sessions recorded that movements representing feelings about positive feedback as well as feelings about achieving success were expressed through more extended, elongated and open movements. It is also documented that the participants' movements gained more control, coordination and focused direction as the sessions progressed. The researcher's process notes for Session 8 reflected that the participants' movements had generally taken on a more expanded, elongated and open character, employing more of their surrounding space in comparison to the movements performed during the initial sessions of the programme. The process notes also supported the notion that the participants first gained confidence in executing their structured movement sequences, but that that confidence and sense of capability spilled over into their improvised movements by the time they reached Session 8.

In the participants' reflections in their personal DMT Journey Journals, the concepts of needing and gaining confidence as well as the discovery of capabilities or feeling more capable are continually repeated. Due to their not being experienced dancers, their reflections did not address aspects such as range and quality of movement or use of space, but they did contemplate on how it became easier to create, execute and share movements as the sessions progressed.

Patterns of movement deserve a significant mention in this section, as this seemed to be indicative of how the participants acknowledged, processed and accepted the way in which their diagnosis of low vision had affected their self-esteem prior to the DMT intervention programme. As mentioned in Section 4.3.2.1, the observation schedules indicated that initial sessions produced self-soothing patterns of movement such as the participants wrapping their arms around themselves and swaying back and forth or from side to side, but, as noted in the observation schedules, from Session 4 onwards a new pattern started emerging as the participants' movements started to symbolise a sense of freedom. The process notes in the researcher's diary also documented this alteration in patterned movements and interpreted it as symbolic of releasing or letting go of the way their diagnoses and society's reaction thereto had previously broken down their self-esteem. Participants' reflections in their personal DMT Journey Journals from Session 4 onward also revealed how they were dealing with and transcending their diagnosis of low vision and the personal and social challenges that have accompanied these.

4.3.2.4.1 How does this relate to psychosocial well-being?

As mentioned in Chapters 1 and 2, self-esteem is a determining element not only of the psychological but also of the social constituents of psychosocial well-being. These chapters also explain how this association is adversely affected not only by the physical diagnosis of low vision, but also by the individual's personal traits and capacities as well as the person's immediate and broader social system's responses to and contending with their visual impairment. The fact that all three data collection procedures indicated how they were engaging with the reality of their diagnoses during the DMT intervention programme and how they were able to acknowledge, process, accept and transcend this aspect of their physical being, therefore not only implies a healing of self-esteem but also suggests an advance in psychological well-being. The participants' observation schedules as well as the process notes in the researcher's diary reflected development in each of the participant's physical abilities to engage in and execute the movement sequences of each respective session, while the participants' reflections in their personal DMT Journey Journals not only attested to progress in physical capabilities but also spoke of discovering strengths and passions which

they were previously unaware of – all of which contributed to an increase in self-esteem and again, by association, psychological well-being.

Section 4.3.2.3 already noted the connection between established group cohesion and an increase in self-esteem, and the data analysis of the data collection strategies for this particular section also revealed that the above-mentioned increase in psychological well-being yields an immediate implication for social well-being as well. As participants engaged in the DMT intervention programme, they were granted the opportunity to receive the accepting and encouraging feedback which informed and understanding micro and macro systems would provide. In response to this, they were given the chance to play a significant and contributing role in other participants' sense of well-being, which would be expected of a social system which comprehends the abilities and needs of persons with low vision. Needless to say, the constructive feedback and ability to contribute led to an enhancement of self-esteem, and specifically contributed to a greater sense of social well-being.

Therefore, it may be surmised that a transcendence of their visual impairment, an increase in their physical capabilities as well as the simulation of positive social interactions, were contributing factors to an increase in self-esteem, and that the very psychological and social nature of these constituting aspects contributed to a greater feeling of psychosocial well-being.

Finally, it is with these above-mentioned determining factors that the next section will be concerned, in an attempt to address the research sub-question posed in Section 3.2: What will the Dance/Movement Therapy intervention programme entail?

4.3.2.5 Theme 5: Main contributing factors to improved self-esteem

Although the psychosocial needs of adolescents with low vision, which were illuminated through the literature study conducted in Chapters 1 and 2, informed the content of the DMT intervention programme, it became clear as the programme progressed and the data gathered from the various data collection methods was studied, that the DMT programme should be centred on the aspects below.

All DMT sessions should follow a stipulated routine. This creates a sense of familiarity which contributes to the ability-promoting environment which was referred to in Section 4.3.2.3. This need for predictability was observed in each participant's observation schedules, was noted in the process notes of the researcher's diary and was reflected upon in the participants' personal DMT Journey Journals. For the same reason, structured movement should also be included in each session, as it requires planning and repetition which leads to

a certain degree of dependability. This further contributes to a greater sense of control, which is another element that was emphasised in the collected information from all three data gathering methods.

While Section 4.3.2.3 professed to the importance of collaborative movement sequences, the relevance of including independent movement was also made apparent through the study of the different data collection procedures. Engaging in independent movement sequences granted the participants the opportunity to experience success on their own accord which in turn contributed to improved self-esteem.

This experience of success should however not be limited to that which feels familiar and consequently makes the participants feel safe. Sessions should include realistic challenges on a scaffold basis to present participants with the opportunity to step outside their comfort zones, attempt something that they consider themselves incapable of doing yet find themselves overcoming, through facilitation within the accepting and ability-promoting environment in which the DMT intervention programme functions. This simulation of overcoming challenges encourages the actual transcendence of their low vision and facilitates the process of removing the "dis-" from "disability". This is why adding to and alternating warm-up and cool-down sequences as well as the inclusion of improvised movement sequences in each respective session proved to be of value.

The participants' need to be empowered and enabled was also accentuated during the study of their observation schedules, the process notes from the researcher's diary as well as their reflections in their personal DMT Journey Journals. This suggests that the DMT intervention programme must not just aim at providing a therapeutic intervention to address the participants' low levels of self-esteem but must also equip them with skills which can be applied after the termination of the programme in order to sustain or even further improve the levels of self-esteem which participants reached after the intervention was completed.

Finally, each session should fashion opportunities for the participants to add value to the well-being of fellow group members and even to the facilitator, as the need to play a meaningful role in and make a significant contribution to their social systems was also stressed when studying the data collection strategies.

4.3.2.5.1 How does this relate to psychosocial well-being?

The fact that each DMT session followed a similar configuration did not only contribute to an ability-promoting environment within which self-esteem could be cultivated, but also contributed to improved self-esteem in itself, as the growing sense of familiarity granted participants the opportunity to master certain skills and subsequently experience success.

Furthermore, although each session's structured movement sequence required innovative movements from the participants, the fact that they had time to plan and prepare these movements and that they repeated the sequences once or twice, also set the scene for them to gain confidence in their capability and experience success. Gaining a greater sense of independence also added to an increase in self-esteem. Since self-esteem is a determining factor in psychological well-being, the development of the former inadvertently contributed to an enhancement of the latter. The scaffolding of challenges as participants gained mastery of certain movements, meant that they were not tested beyond their abilities and thus preserved the ability-promoting environment of the DMT setting, but also allowed them to discover the extent of their capabilities within these safe surroundings and to realise their ability not only to transcend the challenges posed to them, but also ultimately to transcend the trials encapsulated by their visual impairment. Both the experience of success beyond what they thought they were capable of and the transcendence of their impairment contributed to an improvement in self-esteem and therefore in return their psychological well-being as they shifted their self-perception from being disabled to being able.

The skills of expressive movement which the participants acquired during the DMT intervention programme not only enabled them to better express themselves and communicate their feelings but also extended to self-calming and reflecting skills which allowed them to manage daily stressors more effectively. This sense of enablement and empowerment not only contributed to a greater sense of self-control and a development in self-esteem, but also enhanced social interactions and mediation of the challenges presented within their social systems, subsequently adding not only to psychological welfare but also to improving social well-being.

In conclusion to this section, the opportunity to make valuable contributions to other participants' self-worth during each respective session not only made the participants feel needed and therefore contributed to their sense of self-worth, it also granted them the experience of positive social interactions, thus improving both psychological as well as social well-being. The fact that the constitution of the DMT intervention programme promotes both psychological as well as social elements therefore establishes that its implementation can lead to the improvement of psychosocial well-being.

Now that the qualitative data has been extensively analysed and discussed, the results of this section will be placed side by side with the quantitative data as presented in Section 4.3.1.

4.3.3 Comparing quantitative and qualitative data sets

When comparing the qualitative and quantitative data sets, both the quantitative data in the form of the RSES pre- and post-intervention scores as well as the qualitative data as surmised by the observation schedules, process notes in the researcher's diary and the participant reflections in their personal DMT Journey Journals, indicate an improvement in self-esteem of each respective participant, but to varying degrees. This means that a convergence between the two collections has been achieved. While the qualitative data results indicate a general enhancement in the self-esteem of each participant, the pre- and post-intervention scores of the RSES specifies to what extent each participant developed with regard to her level of self-esteem.

Herewith follows a visual representation of the convergence between the two data sets to better clarify the association between the two:

Participant	Improvement in self-esteem According to RSES	Improvement in self-esteem according to observation schedules	Improvement in self-esteem according to reflection in DMT Journey Journal	Improvement in self-esteem according to process notes
A	YES	YES	YES	YES
B	YES	YES	YES	YES
C	YES	YES	YES	YES
D	YES	YES	YES	YES
E	YES	YES	YES	YES
F	YES	YES	YES	YES

Table 4.2 Comparing quantitative and qualitative data of each respective participant

4.3.3.1 Comparing quantitative and qualitative data results of each participant

- Participant A

Participant A scored 14 on the pre-intervention administration of the RSES which is indicative of a lower level of self-esteem, while her post-intervention score was 18. This

indicates that her level of self-esteem had improved to the extent that it now lay on the normal range of self-esteem. Her observation schedules, as depicted in Addendum R (1), also noted a progressive increase in the range and quality of her movement as well as in her employment of the space around her, which further suggests an enhancement of self-esteem. This advance in self-esteem was also echoed in the reflections in her personal DMT Journey Journals (cf. Addendum U) as well as noted in the process notes of the researcher's diary.

- Participant B

The pre-intervention score on the RSES for Participant B was 13, which pointed to low self-esteem. For the post-intervention administration of the RSES she scored 16. This means that her self-esteem developed to the extent that she moved from the low self-esteem range to the normal self-esteem scale. Participant B's observation schedules, as noted in Addendum R (2), reflect that her movements elaborated in scope and the use of space and that the quality thereof also developed from restricted, wilted and rapid to strong, extended and sustained movements. Her reflections in her personal DMT Journey Journal (cf. Addendum U) documented how she increasingly felt better about and believed in herself, while the researcher's process notes affirmed the other data collection strategies' findings of improved self-esteem.

- Participant C

This participant scored the determining limit between low and normal self-esteem, i.e. 15, on the pre-intervention completion of the RSES. Her score on the post-intervention administration of the RSES was 16, which remains low on the normal range of self-esteem. This slight improvement in self-esteem could be attributed to the fact that she only attended four of the eight DMT intervention sessions as she was first sick with tonsillitis and then fell ill with the flu. Although only constituting four sessions, her observation schedules, as documented in Addendum R (3), indicated a development in the span and properties of her movement sequences as well as an advanced utilisation of her surrounding space and the levels thereof. Her reflections in her personal DMT Journey Journals (cf. Addendum U) contained evidence of significant relational challenges which could also explain her limited progression on the self-esteem scale. Her reflections did however also document how her sense of well-being improved towards the end of each session and how she was gaining more confidence in herself and in others. The process notes in the researcher's diary substantiate an improvement in self-esteem.

- Participant D

Participant D's pre-intervention score was indicative of very low self-esteem as she scored 10 on the first administration of the RSES, while her post-intervention score for the RSES escalated to 19, moving her high onto the normal self-esteem range. The observation schedules noting her movement across the eight DMT intervention sessions, as can be scrutinised in Addendum R (4), recorded a progressive expansion and extension in her range of movement and also documented an enhancement in the quality with which she executed these movements. While her initial reflections in her personal DMT Journey Journals (cf. Addendum U) documented her fear of being judged and rejected, these deliberations progressed to include self-acceptance and self-assurance, which are indicative of an improvement in self-esteem. The researcher's process notes acknowledge her personal growth and subsequent improvement in self-esteem.

- Participant E

Although Participant E showed an increase in her pre- and post-intervention scores on the RSES, which were 11 and 14 respectively, she remained on the low self-esteem range of the self-esteem scale. Her observation schedules recorded for the respective eight sessions, as indicated in Addendum R (5), showed development in the capacity and attributes of her movements as well as the employment of her proximate space. Her reflections in her personal DMT Journey Journal (cf. Addendum U) also spoke of how she felt increasingly better about herself and her capabilities despite her visual impairment, but also noted how the negative and hurtful attitudes and feedback from persons in her micro system were hampering her development in self-esteem, which could explain why she remained high on the low self-esteem range of the self-esteem scale. The researcher's process notes corroborate the above.

- Participant F

Participant F's pre- and post-intervention scores also indicated an increase in self-esteem but remained on the low self-esteem scale. Her score for the pre-intervention administration of the RSES was 10, while her post-intervention score was 13. Her observation schedules, as can be referred to in Addendum R (6), marked a slight improvement in range and quality of movement, but regressed in Session 4 when she felt less experienced and competent in comparison with the participants who were one or two years older than she was. With determination and perseverance, she did manage to develop the span and properties of her movement and succeeded in utilising her contiguous space, which ultimately implied an improvement in self-esteem. Her reflections (cf. Addendum U) also noted her gain in

confidence and self-acceptance from Session 5 onwards, but the set-back she experienced in Session 4 might explain why her self-esteem had not improved to the extent of falling on the normal range of the self-esteem scale. The process notes documented in the researcher's diary validate this notion.

The next section will proceed to interpret the data which was analysed in the previous sections of this chapter.

4.4 INTERPRETATION OF DATA

The content of this section will relay the interpretation of the analysed data from Section 4.3 within the conceptual framework of the literature study conducted in Chapter 2. The empirical research directed by the data attained through the pre- and post-intervention administration of the RSES, as well as the observation schedules and process notes documented while observing the DMT intervention sessions, along with the participant reflections in their personal DMT Journey Journals, established that there were psychological as well as social factors which determined low levels of self-esteem in the adolescent girls with low vision prior to the participants' engagement in the DMT intervention programme, and that the reversal of these factors as constituting elements of the DMT intervention programme not only addressed the issue of low self-esteem due to low vision but promoted the improvement thereof as well.

These determining factors as reviewed in the literature study in Section 2.4.2 of Chapter 2 which discusses the psychosocial impact of low vision and which were also evident in the results from the data analysis are as follows:

4.4.1 Psychological factors

4.4.1.1 Perception of independence and loss of control

As this element will also feature as a social factor, it needs to be noted that in this instance the person with low vision's degree of independence is viewed from an inside-out approach.

Morse (2004: 44) states that an individual with low vision's sense of dependence or independence is a determinant element of such a person's identity and subsequent self-esteem. Opie (2018: 75), Sacks (2010:68) and George and Duquette (2006: 3) agree that this guides the degree to which they engage in and with their social systems which in turn affects their extent of self-acceptance. Section 4.3.2.1.2 describes how a lack of opportunities for participants to engage in independent behaviour impedes the development of self-esteem as the prospects of experiencing success, imparting a valued contribution to their immediate or wider social systems and subsequent personal growth elude them. Their

lingering low level of self-esteem continues to reflect in their collective interactions which substantiate their micro and macro systems' rigid conceptions of their sensory impairment. Moreover, in Sections 4.3.2.5 and 4.3.2.5.2, the data analysis shows that creating opportunities for independent action through individual movement sequences allowed participants to experience success through their own innovation which enhanced their self-esteem and subsequent psychosocial well-being.

4.4.1.2 Physical passivity

Section 2.4.2.3 of Chapter 2 discusses the extent to which individuals with low vision engage in passive activities such as watching television and listening to music (Barstow, 2018: 4; Choi et al., 2018: 1; Inoue et al., 2018: 2; Sacks, 2010: 80; Keefe 2005: 170; Burmedi et al., 2002: 49). Morse (2004: 46) explains that this relates to their negative body image as they do not receive accurate feedback about the functional capabilities of their bodies. Section 4.3.2.1.2 explains how bodily features such as deficient posture and restricted movement indicate a noticeable effect on participants' body image which is not only a contributing factor to self-esteem, but also a defining characteristic in regard to the quality of their communal interchanges as it encapsulates the manner in which they portray themselves to the outside world. This inevitably influences the social responses which they receive in return and subsequently contributes to already low levels of self-esteem.

Data gathered from the empirical study and relayed in Sections 4.3.2.4.2 and 4.3.2.5, describes how the successful execution of structured movement sequences as well as transcending the challenges posed by increased difficulty levels of warm-up and cool-down exercises and improvised movement sequences led to the participants' discovery of their physical abilities and that their increased sense of capability contributed to the development of their self-esteem. The added psychological benefit of engaging in physical activity which is stipulated in section 1.4 of Chapter 1, such as promoting self-esteem and character development as explained by Niemann (2002: 310), is also affirmed in Section 4.3.2.4 which surmises how self-esteem had improved with the implementation of the DMT intervention programme.

4.4.1.3 A sense of belonging

In Section 2.4.2.3, Sacks (2010: 69) describes how persons with low vision do not associate with the population with normal range of sight nor with their blind counterparts in what he describes as the "neither fish nor fowl" phenomenon which implies that they do not have a clear directive which informs their social standing or subsequent conduct. Morse (2004: 47) validates this phenomenon by explaining that not belonging to a specific classification or category has a direct impact on a person with low vision's self-perception and inadvertently

affects his/her self-esteem. Section 4.3.2.3, which elaborates on the significance of conducting the DMT intervention programme in a group format, ascertained the above-mentioned need for persons with low vision's sense of belonging as it was indicated that the participants' improvement in self-esteem not only correlated with the establishment of group cohesion but specifically referred to the sense of camaraderie which was established when deciding on a group name as it was founded on the participants' agreement of how they are perceived by the outside world.

4.4.1.4 Managing stressors of the sighted world

Sacks (2010: 78) refers to how coping with the challenges presented by the person with low vision's immediate and wider social system which functions according to the norms dictated by normal range of sight can adversely affect an individual with low vision's self-esteem and therefore also his/her sense of psychosocial well-being. Section 4.3.2.5 depicts how participants were able to handle day to day stressors more efficiently through the expressive movement, self-calming and reflection skills which they developed through their participation in the DMT intervention programme. It continues to describe how they felt enabled and empowered and how this contributed to an increased sense of self-control and subsequent enhancement in self-esteem. This extended to the quality of their social interactions as they were better able to articulate and convey their thoughts and feelings, which boosted their self-confidence and inadvertently improved their level of self-esteem.

4.4.1.5 Transcendence of low vision

Morse (2004: 47) explains in Section 2.4.2.3 of Chapter 2 that the factors as mentioned in Sections 4.4.1.1 through to 4.4.1.4 hinder the person with low vision's ability to transcend his or her visual impairment. Sections 4.3.2.4 discusses how observed developments in the participants' patterns of movement symbolised how they recognised, dealt with and conceded to the manner in which their low vision had impeded their self-esteem in the past as self-comforting patterns of movement such as hugging themselves and swaying to and fro made way for movement arrangements which were characterised by a sense of release. The researcher's process notes also noted this shift in movement patterns and interpreted this alteration as emblematic of how the participants were distancing themselves from the way their own as well as the wider social systems' perceptions of their diagnoses of low vision deconstructed their sense of self-esteem. The participants' reflections in their personal DMT Journey Journals confirmed how they were processing and ultimately transcending their visual impairment as well as the personal and social trials which were associated with it.

In accordance with the above, Section 4.3.2.4.2 describes how the fact that all three data collection strategies reflect their engagement with the actuality of their visual impairment during the DMT intervention programme as well as their capability to acknowledge, work through, accept and ultimately transcend their diagnoses of low vision and all it encapsulates, suggests a mending of their self-esteem and the inadvertent enhancement of their psychological welfare.

Finally, the results of the data analysis as stipulated in Section 4.3.2.5, describe how the DMT intervention programme presented participants with challenges, scaffolding these trials as they mastered specific movement sequences, and how this allowed them to transcend these challenges within the accepting surroundings of the DMT setting while discovering their abilities to overcome said challenges and extend these capabilities to also transcend their low vision. It also discussed how the participants' encounters with personal success which extended past their perceived capabilities along with the transcendence of their visual limitations, contributed to a development in self-esteem and inadvertently improved their sense of psychosocial well-being as their perceptions of themselves altered from being disabled to being able.

4.4.2 Social factors

4.4.2.1 Interactions with immediate and extended family

Choi et al. (2018: 1), Opie (2018: 75), Sacks (2010: 82), Morse (2004: 45) and George and Duquette (2006: 6) have conducted research on how the degree to which an individual with low vision's family is informed about their psychosocial needs can either support or hamper the person with low vision's acquiescence and adjustment to his/her visual impairment. In Section 2.4.2.2 of Chapter 2, Sacks (2010: 79) explains how family traditions and normative values can influence the individual's transcendence of low vision. Modern day families who are informed about their child's diagnosis will acknowledge their child's independence and proficiency and will encourage his/her significant involvement in and contribution to the domestic setting, while less informed families might smother such independent behaviour as it is believed that the person with low vision is not capable of executing actions autonomously (Sacks, 2010: 74).

Section 4.3.2.2 discusses how the applicable observation schedules, process notes and reflections in the participants' personal DMT Journey Journals relay how the participants' immediate social systems do not facilitate independent behaviour which in turn would allow participants the opportunity to exhibit their capabilities. This deprives them of the prospect of experiencing success and making a valuable contribution to the family system, which would contribute to a higher level of self-esteem. Their remaining low self-esteem in turn reflects in

the uncertain nature of their social interactions which then once again affirms their family members' predetermined ideas about their inability to function independently.

In conclusion to this section, Section 4.3.2.5 describes how the occasions presented by every particular session to impart indispensable assistance and support to fellow participants, enhanced the participants sense of self-worth as they felt needed by others for a change. It also simulated very much needed positive social interactions which improved their self-esteem and also attributed to a greater sense of psychosocial well-being.

4.4.2.2 Interactions with peers

The pertinence of the quality of a person with low vision's social exchanges with his/her peers is elaborated upon in Section 2.4.2.2 of the literature study. Morse (2004: 47) and Sacks (2010: 78) explain that these interactions are defining of the extent to which an individual with low vision is able to integrate their visual impairment with his/her psychological and social welfare. The reality of the matter remains however that a person with low vision does not fall within either the sighted or the blind category, which implies mixed social signals pertaining to his/her capabilities and aspirations that leave the person confused with regard to his/her identity, self-worth and subsequent standing within his/her peer group (Morse, 2004: 48).

Section 4.3.2.1, which relays the findings of the empirical study, deliberates on the uncertainty with which participants' initial interactions within the DMT intervention programme are characterised and how this can be misconstrued by persons outside of the DMT group. This can be extended to their interactions with their peers as well. The same section contemplates on how the participants constructed the code of conduct around an effort to shield themselves from further attacks on their self-esteem. Should this cautious behaviour reflect in their daily social exchanges with their peers, it may be surmised that they restrict their encounters to a few trusted individuals and also reduce their conduct to actions which they are assured of executing successfully. In doing so, they deprive themselves of an improved sense of psychosocial well-being as they withhold themselves from engaging in elevating encounters.

Section 4.3.2.3, which expounds on the relevance of presenting the DMT intervention programme in a group configuration, states that there was a correlation between increased unity within the group and the participants' improvement in self-esteem, which affirms the statement made by Morse (2004: 47) and Sacks (2010: 78) that a person's social engagement with his/her peers is a determining element in the individual's psychosocial well-being. This section proceeds to explain how the participants' reflections in their

personal DMT Journey Journals indicated that the support and motivation which their peers provided during each of the sessions added to an increased sense of self-value. These reflections further pointed to the degree in which the opportunity to assist and encourage their peers in return contributed to feeling better about themselves.

Lastly, Section 4.3.2.5 again affirms the significant role of peer interactions for persons with low vision as it stipulates how the configuration of the DMT intervention programme created opportunities for the participants to share constructive guidance and motivation with their peers within the DMT group in order to address their need to feel valued. Once again this section also spoke of how the simulation of positive interactions between each participant and her peers also produced an improvement in self-esteem and subsequent psychosocial well-being.

4.4.2.3 Interactions with the wider social system

Section 2.4.2.1 of Chapter 2 discusses the role of the person with low vision's macro system in the establishment of his/her psychosocial well-being. Corn and Lusk (2010: 4), as well as Goodrich and Heubner (2010: 35), explain that the wider social system is not informed about low vision and the unique implications this diagnosis yields for the person with low vision's psychosocial well-being. This causes the ocular conduct and the aforementioned needs of the person with low vision to be misinterpreted and misunderstood. The subsequent result is the social segregation of the individual with low vision as he/she would rather withdraw from social engagements than be treated in the way in which society treats that which it cannot comprehend (Sacks, 2010: 68).

Section 4.3.2.1 notes the withdrawn and uncertain manner in which participants initially engaged with the facilitator and each other during the first sessions, and how this also reflected in their early movement sequences as well. In Section 4.3.2.2, the conceptualisations of Corn and Lusk (2010: 4), Goodrich and Heubner (2010: 35) and Sacks (2010: 68) are reflected in the process notes documented in the researcher's diary, as the participants' distrust of their social systems' ability to cultivate their self-esteem and sense of psychosocial well-being were noted during Sessions 8 and 9.

In Session 8 the participants requested to keep their visual depiction of their structured movement sequence in order to serve as a reminder of the strides they had made in transcending their visual impairment and its accompanying psychological and social challenges, in the face of the onslaughts on their self-esteem which they expected to be confronted with when engaging with the outside world after the programme had been

terminated. During Session 9 the participants expressed their inclination to take the code of conduct which they had compiled, out into their broader social system as it gave them a sense of safety. Later on in the session they also commented on how the poem “I love being me”, which was employed as a stimulus for the session’s improvised and structured movement pieces, bore particular significance to the manner in which they experienced their wider social environment’s misconceptions about them and their abilities.

Section 4.3.2.3.2 makes mention of the alternative as it describes how the participants’ ability to relate to their peers pertaining to their convictions, feelings and experiences of their social systems within the DMT setting, alleviated their sense of isolation and made them feel recognised and appreciated, which contributed to an improved sense of psychosocial well-being. The same point with regard to independence is raised as a social factor as it is broached in Section 4.4.1.1, where it relates to psychological effects, and therefore the perception from which it is studied has now shifted to an outside-in approach. From this extrinsic perspective, the extent to which the person with low vision has access to his/her extended social environment is determinant of the degree to which he/she is presented with opportunities to act independently within the greater social system and subsequently influences the individual with low vision’s identity as well as his/her self-esteem (Opie, 2018: 75; Sacks, 2010: 68; George & Duquette, 2006: 3; Morse, 2004: 44).

Section 4.3.2.2.2 discusses how all three data collection strategies reflect the manner in which participants’ broader social system does not present them with the prospect of independent behaviour and the subsequent attestation of their capabilities. Section 4.3.2.1.2 elaborates on how this lack of opportunity to act independently and prove their ability hinders them from feeling what it is like to achieve success and subsequently deters them from personal growth which ultimately encumbers the development of their self-esteem and psychosocial welfare. Furthermore, their need to make a recognised and appreciated contribution to this wider social system is also thwarted, which adds to their already deteriorated level of self-esteem.

The alternative to the above-mentioned is discussed in Section 4.3.2.4.2. The simulation of the positive social interactions which a knowledgeable and comprehending macro system would encourage, granted the participants the chance to serve a noteworthy and contributing function in the construction of the psychosocial well-being of their fellow group members, and in return receive the same quality feedback from their peers within the DMT setting. These affirming social exchanges attributed to an improved level of self-esteem and a greater sense of psychosocial well-being.

Sections 4.3.2.5 and 4.3.2.5.2 describe how the participants' engagement in independent movement pieces facilitated their chance to experience success on their own accord which in turn led to a development in self-esteem and a subsequent enhancement of psychosocial well-being. Furthermore, communal engagement with, and subsequent systemic responses from, the individual with low vision's wider social system are contributing elements to the construction of self-esteem and therefore formative of psychosocial well-being as well. This is mainly due to the fact that persons with low vision fail to notice fine distinctions conveyed through facial expressions and subtle body language, which the population with normal degrees of sight would discern, process, decode and then apply to articulate their emotions and perceptions with regard to themselves and towards others (Choi, Lee & Lee, 2018: 1; Morse, 2004: 49).

Section 4.3.2.2 conveys how the process notes documented in the researcher's diary noted participants' deliberations on the challenges they experience not only when attempting to rationalise their feelings to other people, but also when aiming to understand the emotions and expressions of others as they are rarely close enough to other individuals to observe the slighter particulars communicated in their facial expressions and therefore are also not able to assimilate these nuances into their frame of reference from which they express themselves. The negative responses the participants receive from these misconstrued social interactions and how the hurtful quality of this feedback breaks down their self-esteem are noted in section 4.3.2.1.2, which refers to components of the participants' reflections in their personal DMT Journey Journals that relayed how behaviour towards and references about them hindered them from feeling better about themselves. In contrast to the above-mentioned, section 4.3.2.5.2 indicates that the expressive movement as well as reflection skills which participants acquired during the progression of the DMT intervention programme, had enabled them to express themselves and communicate their feelings more effectively.

As an extension of the writings by Choi, Lee and Lee (2018: 1) and Morse (2004: 49), Hooper and Umansky (2014: 1) describe how a person with low vision's insecurity and fear of being misunderstood supports the imperative function that eyesight performs during collective interchanges through examining others. Hooper and Umansky (2014: 2) cite Diamond (2002) in explaining how a person with low vision is faced with various trials during their social engagements as their restricted vision reduces their ability to scrutinise and construe social prompts, reactions, societal rules and principles.

Sections 4.3.2.1 and 4.3.2.2 describe the participants' fear of making mistakes during initial reflections and their need for the researcher's approval with regard to the content of their reflections. These sections also refer to the manner in which the participants compiled the DMT intervention group's code of conduct around rules which would ensure the safe guarding of their self-esteem. The degree of their vulnerability was also stressed when the participants asked whether the group name and code of conduct would be kept on the wall of the hall between sessions. In addition to the above, Section 4.3.2.4 discusses how the observation schedules as well as the process notes in the researcher's diary on Session 3 noted that participants' movements that represented feelings of failure were restricted, contracted and performed with a hunched posture, while movement sequences which expressed feelings of success, on the other hand, were characterised by more extended, elongated and open movements.

In conclusion to this section, Sacks (2010: 81) states how a scarcity of adult role models with low vision might contribute to feelings of disgrace and a sense of isolation which could adversely affect a younger individual with low vision's self-confidence and ultimately his/her self-esteem and psychosocial well-being. Section 4.3.2.2 depicts the participants' surprised response to realising that there are female role models with conditions resulting in low vision that are accomplished in numerous disciplines of the world of work. The discussion continues not only to emphasise the pertinent role which the macro system plays in forming the participants' self-esteem, but also amplifies the extent to which this same system falls short of creating awareness and subsequently cultivating understanding of the psychosocial needs of persons with low vision. Finally, the section also highlights the degree to which the participants' broader social system contributes to their identity and subsequent self-esteem as it portrays how participants associated to a greater degree with the South African role model.

The interpreted data as set out in this section, will gain further relevance as a result of discussion of the interpretations within the theoretical framework of the biopsychosocial model in the following section.

4.5 THEORETICAL FRAMEWORK

4.5.1 A biopsychosocial model

Figure 2.1 in Chapter 2 provides a visual illustration of the dynamics associating the physical body, motion, involvement and impairment, and the environmental context in which all of these are encapsulated (WHO, 2002: 9). It depicts the interdependence between

constructive involvement in everyday conduct and the extent to which a person's functioning is impaired or enabled, thus explicating why impairment is not limited to the physical, but is in actual fact intricate and complex as it pertains to the body, the psyche and the surrounding environment. This implies that function or dysfunction stems from an affiliation between a person's physical welfare and his/her personal and contextual dynamics (WHO, 2002: 10).

The World Health Organization (2002: 11) therefore proposes that human functioning occurs on three levels: the actual working of the human body, the performance of the individual as a holistic being, and the operation of this encapsulating entity within its social system, thus suggesting that impairment transpires when there is a malfunction in one or more of these constituting components. If impairment results from dysfunction in one or more of these three dimensions, then overcoming the said impairment will need to be addressed on those very same levels.

Vash and Crewe (2004: 155) consider the initial action towards the facilitation of transcendence of impairment to be the point where one stops viewing the physical, emotional and social aspects of a person as distinct and detached units. This call for perceiving an individual's body, mind and environment as intertwined entities is supported by Smart (2001: 130 – 132) who cites Maslow's (1970) theory of self-actualisation, which is attained by cultivating the physical, the psychological and the social – in other words self-realisation is accomplished through the management and acceptance of the impairment and lastly through the participation in the broader social system in a purposeful and significant way despite the impairment.

The results from the quantitative and qualitative data imply a similar process as participants commenced the DMT intervention programme with low levels of self-esteem due to their visual impairment and the psychological and social impediments which accompanied it. Development in their self-esteem was evident in their observation schedules and reflections in their personal DMT Journey Journals as the DMT intervention programme progressed, and they not only had the opportunity of acknowledging, processing and accepting their low vision and its psychosocial impact, but also experienced the enhancement of their physical capabilities and had the chance to simulate positive social exchanges and make valuable social contributions to their fellow group members' self-esteem. Ultimately, improved self-esteem was evident in all the data collection strategies and as self-esteem is a determining element of psychosocial well-being, an enhancement thereof could also be deduced.

The interpreted data from Section 4.4 will now be organised within a biopsychosocial framework, not only to illustrate the above-mentioned course towards transcendence of their low vision, but to also indicate how this aids in the improvement of persons with low vision's self-esteem and how this ultimately contributes to a greater sense of psychosocial well-being.

4.5.1.1 Biological functioning

As low vision is classified as a sensory impairment (Du Fue & Fergusson, 2003: 95) and therefore pertains to the physical body, it needs to be considered as a biological function, although it has been established that its influence reaches far beyond a bodily plane and therefore cannot be considered in isolation. Furthermore, its effect on bodily mobility and subsequent contribution to physical passivity is a biological influence which adversely affects self-esteem by contorting the person with low vision's body image due to a disparity in feedback on what his/her body is physically capable of (Barstow, 2018: 4; Choi et al., 2018: 1; Inoue et al., 2018: 2; Sacks, 2010: 80; Keefe, 2005: 170: Burmedi et al., 2002: 49).

The six participants' unsupported posture and limited range in movement at the initiation of the DMT intervention programme had a similar effect on their body image and subsequent self-esteem. This sets off a cyclic effect as their low self-esteem and wrongly perceived sense of incapability again in turn demotivates them from engaging in physical activities. In contrast, the victorious performance of structured movement pieces and the manner in which they overcame physical challenges in the form of more advanced warm-up and cool-down sequences facilitated the realisation of what their bodies are capable of, which motivated them to continue engaging in physical activity through movement – even outside the DMT intervention programme.

The Department of Health (South Africa. Department of Health, 2013) explains how being physically active endorses the development of basic motor skills, is beneficial for cardio-vascular functioning, promotes vigorous muscle and bone development and serves as a preventative measure against illness. Similar benefits are depicted in the writings of Shennar-Golan and Walter (2018: 1530) and Guthold, Stevens, Riley and Bull (2018: 1077). Although aspects such as cardio-vascular functioning and improved muscle and bone development were not studied during the empirical research study, the supporting literature from Chapter 2 along with the observed stronger movements and engagement in extended warm-up sessions, might suggest that this is the case. Nonetheless, the participants' gain in capability in performing movement sequences indicates that the participants' physical well-being had improved because of the mentioned continued engagement in bodily activity.

4.5.1.2 Psychological functioning

A person with low vision's sense of identity and self-worth, as well as his/her extent of self-acceptance, is significantly determined by the degree of independence which his/her micro and macro systems allow (Opie, 2018: 75; Sacks, 2010: 68; George & Duquette, 2006: 3; Morse, 2004: 44). The process notes in the researcher's diary as well as the participants' reflections in their personal DMT Journey Journals contemplated how limited engagement in independent behaviour inhibited their experience of success and their chance to contribute to their social system which is detrimental to their sense of control, their perception of self-worth and subsequent level of self-esteem. When faced with such opportunities within the DMT intervention programme, however, an improvement in the participants' self-esteem could be noted as the programme progressed.

For a person diagnosed with low vision, the ambiguous nature of this type of visual impairment causes him/her to feel excluded by his/her fully sighted or blind peer groups, which in turn leaves him/her without the apparent guidelines according to which he/she can conduct him/herself during interactions with others. This shapes their self-perception which in turn impinges on their level of self-esteem (Sacks, 2010: 69; Morse, 2004: 47). However, the former and the latter were addressed by conducting the DMT intervention programme in a group format as a sense of camaraderie and an establishment of group cohesion provided participants with a sense of belonging, inadvertently altered their self-perception and subsequently contributed to higher levels of self-esteem.

The person with low vision's ability to manage stressors pertaining to the sighted world, is determinant of his/her perception of self-efficacy and subsequently also involves the person's level of self-esteem (Sacks, 2010: 78). The interpretation of the collected data highlights how participants were more capable of dealing with these daily stressors with the expressive movement, self-calming and reflection skills with which they equipped themselves as the DMT intervention programme ran its course. This gave them a sense of enablement and empowerment which produced a greater perception of self-control and contributed to gains in self-esteem. To conclude this section, it is clear that dimensions constituting self-esteem, such as a sense of identity and self-worth, self-perception, a sense of belonging and self-efficacy, as well as a sense of enablement and empowerment and a subsequent perception of self-control, are building blocks which construct a greater sense of psychological well-being.

4.5.1.3 Social functioning

The extent to which a person with low vision's family knows and comprehends the communal challenges and consequent social needs unique to his/her visual impairment, determines whether the individual's autonomy and aptitude are acknowledged and supported or discounted and oppressed (Choi et al., 2018: 1; Opie, 2018: 75; Sacks, 2010:74 – 82; Morse, 2004:45; George & Duquette, 2006: 6). The same applies to a person with low vision's extended social environment (Corn & Lusk, 2010: 4; Goodrich & Heubner, 2010: 35).

Participants' observation schedules and reflections, as well as the researcher's process notes, documented how this prohibited them from experiencing success, proving the extent of their abilities or providing a valued contribution to their immediate and broader systems. Their sense of disempowerment and insignificance in turn tainted their social interactions with insecurity, thus validating the notion that they are indeed incapable of independent and contributing functioning. In contrast to this, an improvement in the quality of the participants' social exchanges was noted as each DMT intervention session presented them with the opportunity to create and exhibit independently constructed movement pieces as well as the chance to play a contributing role in support of other group members.

The extent to which persons with low vision are able to assimilate their low vision with subsequent social welfare, is to a large extent determined by the value of their social interactions (Sacks, 2010: 78; Morse, 2004: 47). Morse (2004: 48) however explains how the individual with low vision's station in relation to his/her peer group is influenced by differential social cues relevant to his/her abilities and objectives as he/she does not classically fall within either the sighted or the blind category. This leaves such individuals perplexed about how to approach and engage with their fully sighted peers, which has an adverse effect on the quality of their social encounters as they feel misunderstood and underestimated.

This reality stands in stark contrast to the need for positive social interactions characterised by encouragement and support as was noted through the various data collection strategies during the empirical research study. The collected data suggests that the cautious manner in which participants initially approached social exchanges within the DMT sessions, was characteristic of how they engaged with their peers outside of the programme as well, and that this would imply that they not only limit their interactions to a small number of entrusted individuals, but also that they confine their behaviour to actions which they know they can

perform successfully, thus denying themselves the potentially uplifting relations which they so desperately need to enhance their social welfare.

This notion is supported by participants' reflections in their personal DMT Journey Journals which documented how the motivation and support they received from other group members along with the chance to play a similar supportive and encouraging role made them feel more socially engaged. Similarly, the way in which an uninformed macro system misconstrues a person with low vision's visual behaviour causes the individual to withdraw from collective encounters in fear of the hurtful responses which are founded on pure ignorance (Sacks, 2010: 68).

The participants' degree of distrust in their wider social systems was documented in their reflections in their personal DMT Journey Journals as well as in the researcher's process notes on Sessions 8 and 9. Participants' sense of segregation was eased however as they were able to relate to other group members with regard to their thoughts and emotions about and perceptions of their social environments within the DMT setting. This gave them a sense of acknowledgement and appreciation that contributed to a greater sense of social welfare. Akin to their interactions with their sighted peers, persons with low vision's interactions with their macro system and the responses which stem therefrom are also complicated by the challenge of observing distinctive details portrayed in strangers' facial expressions and body language. Consequently, they cannot employ such annotations to decipher, process and comprehend personal or social perceptions (Choi et al., 2018: 1; Morse, 2004: 49). Due to this very reason, a person with low vision is apprehensive about being misunderstood or experiencing failure (Hooper & Umansky, 2014: 1).

The participants in the DMT intervention programme also reflected on the difficulties they were confronted with when attempting to understand the emotional reactions of people in their wider social system due to the exact same reason, and how this disparity in their frame of reference made it even more challenging to express their own feelings in a comprehensive manner. The researcher's process notes also documented their fear of making mistakes during their initial reflections and their subsequent need for approval from the researcher. The movement sequences representing their feelings about failure were also marked by restricted and contracted movements. The participants did however indicate that the skill of expressing themselves through movement as well as the skill of reflection had enhanced their ability to convey their thoughts and feelings more efficiently, and their movements depicting how they felt when they achieved success were more open, extended and lengthened.

Lastly, a macro system's incapacity to promote role models who have transcended their own visual impairment to achieve success in various areas in the world of work causes feelings of humiliation and a sense of segregation from the sighted world for the person who has low vision (Sacks, 2010: 81). The participants in the DMT intervention programme had no idea that there were role models with low vision. Having such role models which they could aspire to and emulate, contributes to their social identity, which, along with the aspects discussed in the rest of the section, is determinant of a person with low vision's social well-being.

4.5.1.4 Integrating biological, psychological and social functioning

Figure 4.1 illustrates how biological, psychological and social influences inter-relate with each other to facilitate the transcendence of low vision through active participation.

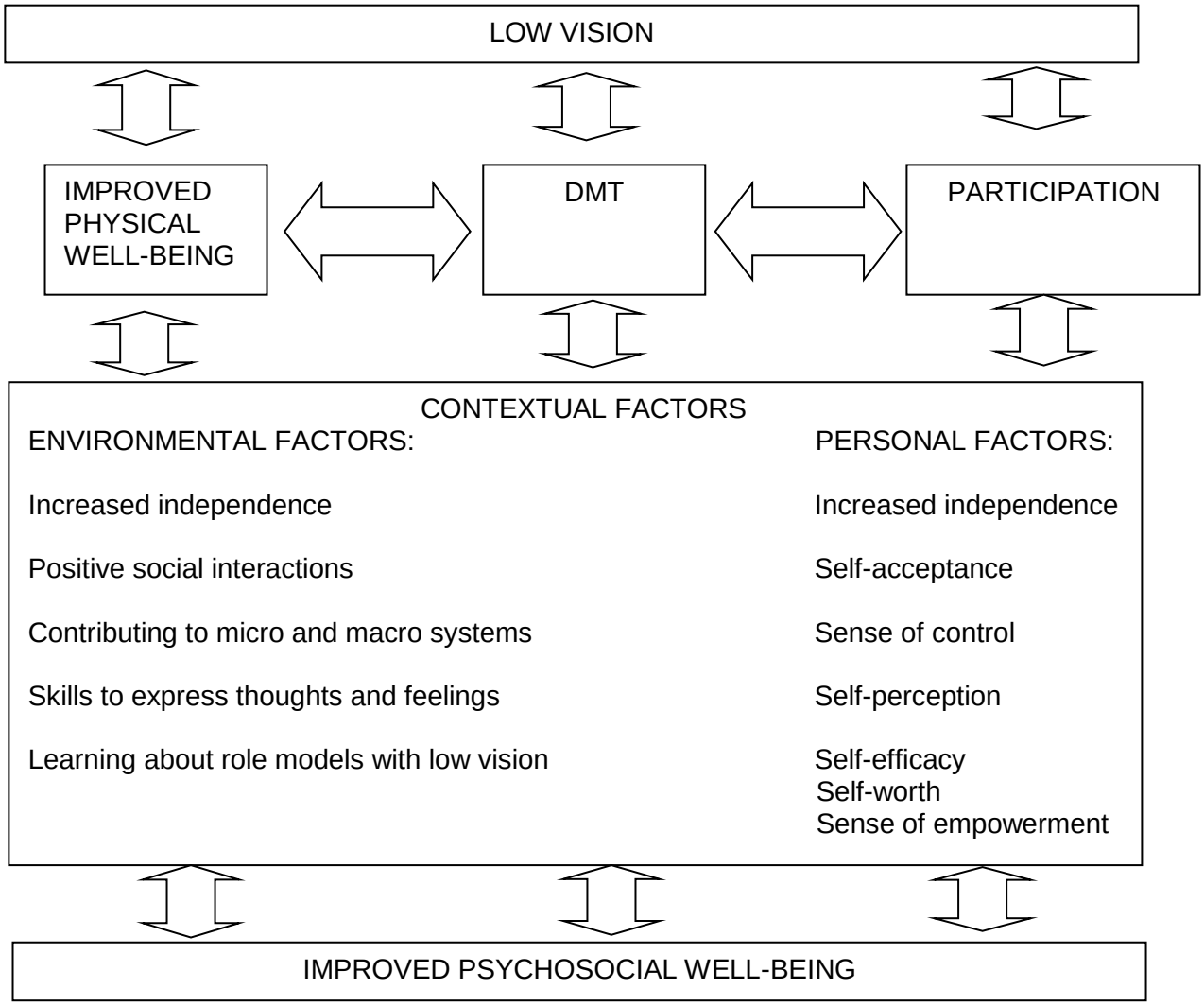


Figure 4.2 An extension of the biopsychosocial framework to include a constructivist paradigm

4.5.2 An extension of the biopsychosocial model to include a constructivist perspective

Due to personal dynamics such as coping techniques being incorporated in the WHO's bio-psychosocial structure, it can be deduced that personal reactions to the environmental factors will differ from one individual to the next (WHO, 2002: 10). Adler (2009: 609) proposes that the existing biopsychosocial model be broadened to include a constructivism theory; this would justify the fact that each participant responded to the DMT intervention programme with varying degrees of improved self-esteem and psychosocial well-being.

4.6 IN CONCLUSION

This chapter analysed and interpreted the results gained from the empirical research in order to facilitate comprehension of a case study which was carried out at a school for the visually impaired in Gauteng. The following chapter will conclude the investigation by relaying a summarised version of the literature study as set out in Chapter 2 as well as the empirical research findings as noted in this current chapter, ultimately addressing the research questions as posed.

CHAPTER 5
SUMMATION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

People with low vision are confronted with a significant and unique set of physical, psychological and social challenges (Bakkar et al., 2018: 631; Moses, 2018: 421) and it is the inability to transcend one or all of these trials which leads to a sense of impairment (WHO, 2002: 11). This research study was conceptualised when the researcher, who is an educator at a school for the visually impaired, became aware of the lack of prospects for participating in physical activities, and how cultural activities, specifically endeavours involving music such as singing and playing musical instruments, are employed to counterbalance this disparity in extra-curricular activities.

This realisation led the researcher to contemplate the prospect of establishing a Dance/Movement Therapy intervention programme founded on the learners' ardour for rhythm and music and their need to engage in physical activities.

The researcher then studied relevant literature (refer to sections 1.1, 1.2, 1.3.2, 1.3.3.1 & 1.3.3.2) to construct the following research question (see sections 1.4 & 3.2):
How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?

The following three research sub-questions were subsequently posed in Sections 1.5.2.1 and 3.2:

- What will the Dance/Movement Therapy intervention programme entail?
- How will an accepting environment which promotes ability be established?
- How did the Dance/Movement Therapy intervention programme influence the participants' self-esteem and subsequent psychosocial well-being?

A decline in the engagement in physical activity amongst contemporary youth is evident (Shennar-Golan & Walter, 2018: 1530; Guthold et al., 2018: 1077) – and even more so for adolescents who have been diagnosed with a sensory impairment such as low vision, keeping in mind that the need for and ability to participate in such activities have been misjudged and undervalued (Inoue et al., 2018: 2; Rimmer & Rowland, 2007: 145; Lansdown, 2002; Longmuir, 2000: 40). The effects of this are far-reaching, as research indicates that the consistency with which an individual with low vision engages in physical

activity as well as the quality thereof extends to his/her level of self-esteem and inadvertently then also impinges on his/her state of psychological and social welfare (Ishtiaq et al., 2016: 431; Keefe, 2005; 167; Wahl, Schilling, Oswald & Heyl, 1999: 304). Consequently, this study aspired to explore how a Dance/Movement Therapy intervention programme might not only create a much needed opportunity to engage in physical activity, but could also potentially address the self-esteem and psychosocial issues with which adolescents with low vision are confronted because of the lack of participation in such physical exercises.

The researcher formulated the following objectives to actualise the above and subsequently to address the posed research sub-questions.

Her first point of intent was to engage in a comprehensive literature study to examine how Dance/Movement Therapy might influence the psychosocial well-being of adolescents with the visual impairment of low vision. In order to do so, the researcher had to investigate the following (refer to Sections 1.5.2.2. & 1.10):

- Defining elements, causes and prevalence of low vision
- The psychological and social implications of low vision
- Possible transcendence of low vision and its psychosocial challenges
- Psychosocial well-being and the constituting factor of self-esteem
- The origin, intent, types and structure of Dance/Movement Therapy
- Amalgamating the physical and psychosocial needs of adolescents with low vision with the goals of Dance/Movement Therapy in order to facilitate transcendence

The next objective was to conduct an empirical study which entailed the implementation of a DMT intervention programme at a school for the visually impaired in Gauteng to determine the following:

- The level of self-esteem of six female adolescent learners with low vision prior to the implementation of the DMT intervention programme
- The content and structure of the DMT intervention programme
- The creation of an ability-promoting and accepting environment which would supplement the usefulness of the DMT intervention programme's implementation and subsequent transcendence of low vision and its psychosocial challenges
- How the implementation of the DMT intervention programme would impact on the participants' self-esteem and subsequent psychosocial well-being.

Therefore, this chapter will summarise the research findings in accordance with above-mentioned objectives, firstly by summing up findings from the appraisal of academic

literature in Chapter 2 and secondly by following this with a summation of the empirical study's findings as set out in Chapter 4. The remainder of this chapter will outline the research conclusions, recommendations, possible opportunities for further study, and limitations to the research. It will end with concluding remarks.

5.2 A SUMMARY OF RESEARCH FINDINGS

The findings from the review of academic literature are summarised in the section to follow.

5.2.1 Findings from reviewing relevant academic literature

The literature study as set out in Chapter 2 served as the basis upon which this study is constructed. It positioned this particular research endeavour within the perspective of a local and an international framework.

The study of relevant literature concentrated on viewing impairment within past and present theoretical frameworks in section 2.2, elaborating on types of impairments in section 2.3 and discussing low vision and its causes, prevalence and impact on psychosocial well-being in section 2.4. It then proceeded to explain the concepts of transcendence and psychosocial well-being in sections 2.5 and 2.6, followed by a discussion on Dance/Movement Therapy in sections 3.1 through to sections 3.6. Section 3.7 described the integration of the physical and psychosocial needs of adolescent learners with low vision and the goals of Dance/Movement Therapy.

5.2.1.1 The literature review on past and present theoretical frameworks

The researcher depended heavily on the theoretical constructions of the World Health Organization (2002) in comprehending the concept of impairment from an enabling point of view. The WHO's International Classification of Impairments, Disabilities and Handicaps (ICIDH), which defined impairment within a purely medical model (section 2.2.1), progressed from including the social and then psychological aspects of impairment (sections 2.2.2 and 2.2.3), to ultimately being replaced by the International Classification of Functioning, Disability and Health (ICF) which altered the emphasis from disability to capability by working from a biopsychosocial model (WHO, 2002: 2). This conceptualisation implies that human functioning occurs on three levels, namely the physical workings of the body and its engagement in activity, the functioning of the individual as a holistic unit which includes aspects such as gender, age, coping styles and social and education background, and finally the operation of this encompassing unit within the social system that includes public attitudes and societal constructions (section 2.2.3). Therefore, according to this theoretical

framework, impairment steps in when there is dysfunction in one or more of these dimensions (WHO, 2002: 11).

The researcher did however extend her interpretation of impairment within this biopsychosocial model to include a constructivist paradigm as Adler (2009: 609) proposed (section 2.2.3), based on the fact that personal dynamics such as coping styles will imply varying reactions to the environmental factors with which the individual will interrelate (WHO, 2002: 12).

5.2.1.2 The literature review on types of impairment

The researcher's engagement with scholarly literature pertaining to types of impairment yielded the following explanations:

Physical impairment refers to problematic functioning of the human body (Section 2.3.1), which in the case of visual impairment has to do with the operation of one of the body's five senses, that of sight (Donald, Lazarus & Moolla, 2014: 293). As explained in section 2.3.2, it is therefore further distinguished as a sensory impairment as well (Longmuir & Bar-Or, 2000: 49; Du Fue & Fergusson, 2003: 95). In section 2.3.3, Carvil (2008: 470) states that vision impairment speaks of a defect in the functioning of the ocular structure. The extent of this deficiency divides vision impairment into two categories which are diagnosed as low vision or blind (Naipal & Rampersad, 2018: 393; Meeus, 1994: 363). Section 2.3.4 explains that low vision in particular refers to a visual acuity which is less than that which is considered for normal functioning eyesight (less than 6/18) but which is still more definite than that of a blind individual (equal to or better than 3/60). A person with low vision may also still retain 20% of field vision, while a blind person's field vision is limited to 10% (Naipal & Rampersad, 2018: 394; Resnikoff et al., 2004: 846).

5.2.1.3 The literature review on low vision

Causes of low vision can be medical, genetic and/or environmental (Barstow, 2018: 3; Bakkar, Alzghoul & Haddad, 2018: 631; Gilbert & Ellwein, 2008: 879). Resnikoff et al. (2004: 844) estimate that of the 161 million visually impaired people worldwide, 124 million were diagnosed with low vision. Further research conducted by Resnikoff et al. (2004: 845), Gilbert & Ellwein (2008:880) and also Barstow (2018: 3), indicate that the prevalence of low vision is disproportionately distributed amongst population groups as it is more frequently diagnosed among females, more dominant in underdeveloped countries and more common among persons aged 50 years or older (section 2.4.1). The most prevalent eye conditions amongst adolescents, however, involve refractive errors which imply a deformity in the eye's

shape and subsequent inaccurate reflection of light that leads to blurred vision, and also degenerative eye conditions that cause central vision loss (Leat, Legge & Bullimore, 1999: 200). Albinism, with co-morbid eye conditions such as nystagmus and homeopathy, is particularly prevalent amongst adolescents of African descent (Bakkar et al., 2018: 631; Resnikoff et al., 2004: 849).

With regard to the psychosocial impact of low vision, the literature review reflected the World Health Organization's biopsychosocial approach to impairment, and Sacks (2010: 67) indicates how the psychological impression of living with low vision will vary based on age of onset, the responses and mindsets of significant persons in the individual's micro system, the extent to which the wider macro system is informed about and prepared for low vision individuals, the severity and progression of vision loss, and distinctive personal characteristics and abilities of the person in question. Bakkar et al. (2018: 631) and Moses (2018: 421) also affirm the extent to which low vision impacts on the person's physical state, emotional well-being and social exchanges (section 2.4.2).

Sections 2.4.2.1 to 2.4.2.3 elaborate on how a person with low vision's interactions with the self, the micro and the macro systems impress on the individual's self-esteem and subsequent sense of psychosocial well-being. Corn and Lusk (2010: 4) as well as Goodrich and Heubner (2010: 35) explain how the fact that the wider social system is uneducated about low vision causes visual behaviour and the needs of individuals with low vision to be wrongfully interpreted and how the subsequent responses of the greater public lead to the social isolation of the person with low vision, who feels misunderstood. Similarly, facial expressions and body language, which people with a normal range of sight are able to observe, process, interpret and employ to inform their exchanges with other individuals, elude a person with low vision, which leads to insecure interactions with their macro systems and in turn have a negative effect on the formation of their self-esteem and subsequent psychosocial well-being (Choi, Lee & Lee, 2018: 1; Morse, 2004: 49).

Sacks (2010: 81) also gives an account of how a lack of adult role models who are visually impaired might cause feelings of shame and isolation which can adversely impede the self-confidence and subsequent level of self-esteem in a child with low vision.

The extent to which the macro system is accessible to persons with low vision also inadvertently impresses on the degree to which they are able to accept and adapt to their visual condition and the subsequent level of their self-esteem, as it either promotes or

discourages independent behaviour when interacting with this system (Opie, 2018: 75; Sacks, 2010:68; George & Duquette, 2006: 3; Morse, 2004: 44).

The writings of Choi et al. (2018: 1), Opie (2018: 75), Sacks (2010:82), George and Duquette (2006: 6) and Morse (2004:45) speak of the extent to which family, peers and immediate professionals such as educators and specialists, contribute to a significant extent to the facilitation of acceptance of and adaption to the diagnosed person's low vision. Once again an extensive understanding of the psychosocial needs of an individual with low vision is pertinent in order to promote and establish the formation of a positive identity and normal level of self-esteem as this encourages independent behaviour within and valuable contribution to the person with low vision's micro system.

With regard to interactions with their peer group, Sacks (2010: 78) and Morse (2004: 47) explain how the nature of these encounters determines the degree to which persons with low vision incorporate their physical condition with their emotional and social state, and the fact that they do not fall into either clear-cut category of sighted or blind yields ambiguous consequences for their social identity, subsequent self-esteem and ultimately their sense of psychosocial welfare.

Section 2.4.2.3 pertained to the self of the person with low vision. Sacks (2010) elaborates on how individuals with low vision – especially adolescents – become anxious as they deal with the apprehension of future vision loss. This, along with the challenge of managing the stressors of the sighted world as well as a possible perception of dependence and loss of control, within their micro and macro systems, are causal factors of depression (Sacks, 2010: 78). To illustrate this, Moses (2018: 420), adds that alarmingly elevated numbers of suicide attempts have been reported among adolescents with visual challenges. Their preference for engaging in passive activities not only adds to depressive symptoms, but also leads to a contorted body image and perception of physical capabilities (Barstow, 2018: 4; Choi et al., 2018: 1; Sacks, 2010: 80; Keefe, 2005: 170; Burmedi et al., 2002: 49). This is further exacerbated by the fact that persons with low vision receive conflicting social feedback when comparing themselves to their sighted counterparts (Morse, 2004: 46) as well as the fact that the degree of their vision can fluctuate, deteriorate and in slight instances improve, which implies variability in their levels of self-esteem as well (Morse, 2004: 47).

5.2.1.4 The literature review on transcendence

The concept of transcendence can be defined as the mental capacity to triumph over substantial impediments presented by the physical body and the surroundings in which it functions, through motivation and determination (Delgado & Humm-Delgado, 2017: 106; McCarthy et al., 2017: 854; Kolcaba, 2003: 75; Mesulam, 2002:8). In essence this is a sense of empowerment and enablement which has been considered as early as the theoretical considerations made by Adler (1979) and Frankl (1969) (Kidd, 2010:10).

With specific reference to low vision, the capability of a person diagnosed with this sensory impairment to transcend his/her diagnosis is connected to the extent to which the person perceives him/herself as purposeful, the degree to which resources in his/her micro and macro systems are accessible, the level of social encouragement, the efficacy of his/her coping skills and the person with low vision's character and temperament (Corn & Erin, 2010). Therefore, transcendence for individuals with low vision encapsulates their capacity to amalgamate their low vision with their self-esteem and social engagements through self-acceptance and positive self-expression (Morse; 2004: 50-51). This is not only representative of the biopsychosocial model, but also of the conceptualisation of well-being consisting of physical, psychological as well as social elements.

5.2.1.5 The literature review on psychosocial well-being and self-esteem

Bradburn (1969: 2) views a person's well-being to be an encapsulating concept as an individual's bodily and mental health are not only interdependent on each other, but also shaped by an equally interdependent social system. Terms such as "embeddedness" and "dynamic interaction" are employed by Tickerhoof George (2005: 8) to describe the reciprocal nature of the association between the biological, psychological and social occurrences from which a person constructs a sense of well-being (section 2.6).

Neff (2011: 2-4), Papadopoulos, Montgomery and Chronopoulou (2013: 4565) as well as Dogan, Totan and Sapmaz (2013: 31) consider self-esteem to be a decisive factor in the determination of a person's psychosocial well-being as it is constructed from a person's perceived degree of capability from a personal as well as social vantage point (section 2.6.1). In section 1.3.2 of Chapter 1, Paradise and Kermis (2002: 345) also relate an improved level of self-esteem to a greater sense of psychosocial well-being because independence, successful social interactions and a sense of purpose are determining elements of self-esteem.

The fact that independence, sufficiency and control is concurrent with an individual's low vision, suggests that his/her physical state will inadvertently influence his/her self-esteem and subsequently, his/her psychosocial well-being (Schinazi, 2007).

The aforesaid influence does not however need to be adverse in effect as adjustments in discernment, feelings, mindset, enthusiasm and mobility are key to facilitating the previously mentioned transcendence of low vision (Tuttle & Tuttle, 2004: 7; Crandell & Robinson, 2007: 98 – 145).

What the above-mentioned scholars are implying is that the person with low vision's potential to overcome his/her sensory limitations – in other words to transcend his/her condition of low vision and successfully adapt to its challenges – lies in the development of his/her psychosocial well-being (Sacks, 2010: 93; Scheiman, Scheiman & Whittaker, 2007: 88; Morse, 2004: 50). Thus, it is comprehensible from the studied literature that the sensory condition of low vision does impinge on an individual's psychosocial well-being, but that the same person also holds the potential to be able to transcend such limitations through constructing and affirming self-esteem and social support (section 2.6.1).

5.2.1.6 The literature review on Dance/Movement Therapy

In section 1.2 of Chapter 1, Dance/Movement Therapy was described as a mode of art therapy which is healing and restorative in nature as it incorporates physical, psychological and social processes as a means of facilitating personal transformation and progress through the employment of dance/movement by amalgamating controllable physical effort, music and sensory prompts (Chaiklin & Wengrower, 2016: 3; Payne, 2006: 3; Goodill, 2005: 15; Malchiodi, 2005: 2; Levy, 1988: 17). In section 2.7 of Chapter 2, Farrell (2009: 90) explains how Dance/Movement Therapy not only permits the expression and release of emotions, but also improves bodily capabilities, which in turn enhances self-confidence and self-esteem. He specifically writes about the advantages for children with sensory and/or orthopaedic impairments, as Dance/Movement Therapy will not only improve these children's body image, but can also develop their self-esteem and social representation (Farrell, 2009: 91).

Dance/Movement Therapy is founded on a biopsychosocial model (Engel, 1977, as cited by Goodill, 2005: 19) similar to the World Health Organization's approach to impairment (sections 2.2.3 & 4.5). It therefore methodically deliberates on how biological, psychological and social features and their multifaceted exchanges influence health (Goodill, 2005: 19). In addition to this, Von Bertalanffy's Systems Theory (1968) also informs the framework from

which DMT as a therapeutic method is studied, because a system is conceptualised as varied features which constitute part of a structured and interchanging process (Laszlo & Krippner, 1998: 64). Connet (2011: 26) states that more contemporary tendencies are also including the Embodiment Theory which places the individual at the centre of development as a dynamic and deliberate agent within an incorporated, compound, active and tailored person-environment system, that by design integrates Piaget's developmental theory in terms of how discernment is derived from the physical (section 3.3).

According to LeFeber (2013: 127) and Meekums (2002: 13), the above-mentioned theoretical frameworks highlight the following fundamental principles of Dance/Movement Therapy:

- Behaviour is a measure of communication,
- movement mirrors personality,
- transformations in movement will ultimately produce alterations of thoughts and feelings, and lastly
- an elaborated movement vocabulary allows for a greater capacity to interact with the environment (section 3.3).

Based on these principles, the contextual framework for DMT is constructed on the following four classifications: body action, symbolism, the therapeutic movement relationship and rhythmic group activity (LeFeber, 2014: 464).

An array of approaches to DMT, originating from a diversity of movement pioneers and stemming from assorted theoretical deliberations, was extensively discussed in section 3.4 of Chapter 2. Certain approaches focus on sensory awareness, while other perspectives employ movement as a form of psychotherapy, expressing and dealing with underlying emotional issues. Some approaches focus on aligned, structured and specific movement sequences, while others encourage spontaneous movement. Then there are also methods which mainly concentrate on improving the efficiency and ease of bodily movement (Payne, 2006: 16). Amongst others, some of these approaches include the Laban Movement Analysis (LMA), Authentic movement (AM) pioneered by Mary Starks Whitehouse, the Mensendieck System of Functional Movement Techniques, Body and Mind Centring (BMC), the movement form of Trager's psychophysical integration bodywork called Mentastics as well as Eastern movement therapies such as Yoga and T'ai Chi (Lavendel, 2016: 210; Movement Therapy Foundation, 2012; Langton, 2007: 17; Cleary 2002: 50-55; Levi, 1988: 22-30).

The following common structure of a DMT session is derived from the mentioned approaches (section 3.5 of Chapter 2): The session is initiated with an introductory warm-up section. From there on the session progresses to a phase of more profound investigation of themes which might be expressed through improvised or structured movement sequences, and then ends with a consolidating cool-down section (LeFeber, 2013: 130; Payne, 2008: 34).

Finally, music is considered a significant and stimulating feature of DMT as it attests to the human body's natural inclination to react to rhythm and more specifically engages alternative senses when working with persons with sensory impairments (Sandel & Kelleher, 2012: 29 – 30; Pratt, 2004: 827). This is particularly relevant to DMT designed for children with low vision as Bertolami and Martino (2002: 2) cite Nordorfand Robbins (1977) as saying that children with visual impairment have an innate predisposition for musicality (section 3.6).

5.2.1.7 The literature review on amalgamating the physical and psychosocial needs of learners with low vision and the goals of DMT

Section 3.7 of Chapter 2 stipulates the aspirations of DMT as follows: It intends to promote a physically and emotionally secure setting; it endeavours to improve body awareness as well as subsequent self-esteem and means to encourage personal growth through elaborating on movement repertoire (Carvil, 2008: 467 – 468; Koch, Morlinghaus & Fuchs, 2007: 344; Payne, 2006: 31; Levi, 1988: 50). In essence the aforementioned is aimed at endorsing the improvement of psychosocial well-being through facilitating a connection between a person's physical encounters, mindful appraisal of emotions and subsequent development in self-esteem, which ultimately allows the person to handle physical, emotional and social demands (LeFeber, 2014: 464; Carvil, 2008: 468).

DMT can therefore address the disparity in persons with low vision's body awareness and subsequent body image by engaging them in physical activity and familiarising them with their surrounding space (Effer, 1995 as cited by LeFeber, 2014: 465). Movement cultivates and establishes positive social interactions through fostering secure attachment relationships by presenting low vision individuals with opportunities to comprehend one another's experiences as well as their own and offers them the chance to communicate such experiences (Devereaux, 2014: 85; Cirino, 2009: 12).

DMT encourages a sense of embodiment through kinesthetically guiding a person to engage with emotions, encounters and memories thereof, which in turn enhances physical, psychological and social welfare. This however requires the person to perceive his/her body

as a secure entity, which an individual with low vision might not hold prior to participating in DMT due to having a distorted body image and spatial perception (Tantia, 2014: 95-96; Devereaux, 2014: 86).

Finally, Cleary (2002: 20), Anderson (2000: 398) and Meeus (1994: 362) elucidate the degree to which low vision is connected to impaired sensory integration and how this results in insufficient motor skills, lesser body awareness and substandard body image, as well as hypersensitivity and even distrust of movement – all of which imply insufficient levels of self-esteem and subsequent challenges engaging with the broader social environment (Anderson, 2000: 399). Cleary (2002: 20) has found that purposeful and focused movement during DMT address the aforementioned difficulties experienced by persons with low vision.

In conclusion of this section, the researcher's engagement with relevant literature indicates that adolescents with low vision have the capacity to transcend their sensory impairment if their unique physical and psychosocial needs are met. Scholarly literature reflects that DMT can be considered a therapeutic intervention which can address a disparity with regard to the mentioned needs as it not only focuses on somatic development, but on emotional and social gains as well.

The next section of this study is concerned with findings from the empirical research conducted.

5.2.2 Findings of empirical research

A synopsis of the findings from the empirical research conducted as described in Chapter 4 is presented in this particular section.

5.2.2.1 Findings from quantitative data collection procedures

The results of the pre-intervention administration of the Rosenberg Self-esteem Scale (RSES) placed five of the six participants on the low self-esteem scale and one participant low on the normal range of the self-esteem scale. Post-intervention completion of the RSES indicated an improvement in each of the six participants' level of self-esteem to varying extents.

5.2.2.2 Findings from qualitative data collection procedures

The following themes were identified as the researcher interrogated the data collected through observation schedules, process notes in the researcher's diary as well as participant reflections in their personal DMT Journey Journals:

- **Theme 1: Indications of low self-esteem prior to and during the DMT intervention programme.** Observed social behaviours during initial sessions were indicative of insecurity and uncertainty. Executed movements reflected similar feelings as range and quality of movements were limited and restricted, and use of space could not be significantly noted. Process notes documented by the researcher as well as participant reflections further substantiated results from the first set of RSES scores and the observed social manners and movement sequences. It was clear that participants commenced the programme with varying degrees of low self-esteem (section 4.3.2.1).
- **Theme 2: The significant role of the micro and macro systems on self-esteem.** A sense of distrust of and vulnerability to the participants' immediate and wider social system was observable in the participants' social conduct and interactions during the administration of the RSES as well as throughout the first six DMT sessions. Movements expressing hurtful feedback, experience of failure and limitations set by their social systems which hindered independent behaviour, were small and contracted in range as well as constricted in quality and rapidly executed. Participants' movements and reflections also indicated that they felt misunderstood and underestimated by the ignorance of their immediate and extended society. A disparity in the feedback process between the participants and their social systems due to their inability to observe, process and internalise facial expressions and subtle gestures was also noted. Lastly, it seems that participants' self-esteem fluctuated slightly with each session depending on the quality of their interactions with their social systems during the day.
- **Theme 3: The relevance of conducting this particular DMT intervention programme in a group format.** Presenting the DMT intervention programme as a group intervention contributed to the cultivation and establishment of an ability-promoting and accommodating environment. Participants performed their strongest and most definite movements when engaging in collaborative movement pieces. They felt a sense of camaraderie with their fellow group members as they faced the same challenges from their micro and macro systems. The researcher documented an association between increased group cohesion and improvement in self-esteem across all eight sessions. Furthermore, the encouragement and support received from other group members as well as the opportunity to provide similar constructive contributions to their peers within the DMT setting, were noted as contributing factors to a greater sense of self-worth and subsequent development in self-esteem and psychosocial well-being.

- **Theme 4: Indications of improvement in self-esteem during and at the end of the DMT intervention programme**. Each participant's observation schedules indicated slight, contracted and limited movements during initial sessions. As the DMT intervention programme progressed, the participants' movements showed development in terms of range, quality and employment of space. The extent of this development varied for each respective participant, but a definite enhancement of self-esteem could be detected in their movements as they were presented with opportunities to transcend manageable difficulties, experience real but relevant success and subsequently gained confidence in their execution of and reflection on their movement pieces as well as in their social exchanges with each other. Furthermore, participants' movements became stronger, more extended and encompassing, and also gained more direction when repetition was required and a sense of physical capability developed with each replication. For the very same reason, participants' structured movement sequences, which were more planned and controlled in nature, gained development in range and quality of movement before their improvised movement pieces. Process notes in the researcher's diary also drew a parallel between more zealous, distinguishing and bountiful movements and an enhancement in self-esteem. Finally, significant patterns of movement emerged and shifted as the DMT programme advanced, starting out as self-soothing hugging and swaying movements and then evolving into releasing movement patterns which represented the concept of transcendence.
- **Theme 5: Main contributing factors to improved self-esteem.** The following contributing factors were identified during the data analysis process and should be included in a DMT intervention programme for adolescents with low vision in order to promote improved self-esteem and subsequent enhancement of psychosocial well-being. All DMT sessions within an intervention programme should follow a similar, specified structure in order to foster a sense of familiarity and dependability as well as facilitate experiences of success, but should also include manageable challenges such as improvised movements to encourage participants to venture outside their comfort zone and subsequently promote personal growth. Although the value of collaborative movement has been made clear, the need for independent movement which can cultivate individual experiences of success and support a greater degree of independence has also been emphasised and should therefore be included in a DMT intervention programme for individuals with low vision. In order to empower participants, the DMT intervention programme should seek not only to address their issue of low self-esteem therapeutically, but should also include skill-building to equip them to better engage with their micro and macro systems. Lastly, the DMT

intervention programme should embed simulations of positive social interactions which not only present participants with opportunities of experiencing positive feedback from others, but which allows each of them to make similar contributions to their fellow participants in order to foster a sense of self-worth which adds to development in self-esteem and psychosocial welfare.

5.3 RESEARCH CONCLUSIONS

Answering the research sub-questions as posed in section 3.2 of Chapter 3 offers conclusions to this particular research study as founded on the academic literature review as discussed in Chapter 2 as well as on the empirical research findings as set out in Chapter 4. Furthermore, these conclusions will allow the researcher to answer the initial research question: How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?

It has to be documented that the conclusions to follow are derived purely from the literature consulted, and assimilated with the empirical research which was conducted on a limited scale. This means that the conclusions which are about to follow cannot be generalised and are relevant only to this specific research endeavour. The conclusions may however point to the value of the implementation of a DMT intervention programme in other educational or communal situations pertaining to low vision. Herewith follow the research conclusions.

5.3.1 What will the Dance/Movement Therapy intervention programme entail?

To ensure the physical and psychological well-being of participants, any Dance/Movement Therapy intervention programme should include a warm-up and cool-down section as well as a time for reflection and consolidation at the end of each session.

More particularly, a Dance/Movement Therapy intervention programme for learners with low vision and low levels of self-esteem should be designed to address the following:

- The self-perceptions of low vision adolescents and their subsequent personal feedback which substantiates these opinions.
- The personal strengths and weaknesses of adolescents with low vision and how they can employ their identified strengths to improve on or even overcome their weaknesses.
- The feedback which these participants receive from their respective micro and macro systems pertaining to:
    - physical abilities,

- social abilities,
- independence,
- reactions to and interpretations of failure, and
- role models with low vision and future prospects of success.

The DMT intervention programme should also allow opportunities for the following:

- A familiar progression of activities
- Collaborative as well as individual movement activities
- Structured and improvised movement sequences

Although the programme should be planned and organised, it should maintain a degree of flexibility in order to accommodate participants' physical, psychological and social needs as they progress through the programme.

5.3.2 How will an accepting environment which promotes ability be established?

The following will contribute to an ability-promoting and accepting DMT setting which cultivates and establishes a sense of capability:

A familiar structure of each session will ensure a sense of predictability which provides participants with the feelings of familiarity and dependability which they do not necessarily perceive within their broader social systems.

Implementing the intervention programme in a group format creates opportunities to relate to others, cultivates a sense of belonging and simulates positive social interactions, but for this to ensue, group cohesion needs to be initiated in the first session and nurtured and confirmed throughout remaining sessions. Collaboratively selecting a group name, designing a code of conduct and signing confidentiality agreements contribute to the former, while the display of the group name and code of conduct during each following session promotes the latter.

Opportunities to experience success and to transcend manageable challenges will not only contribute to an ability-promoting and accepting environment, but the gained sense of support and capability from the encouragement of group members will ensure that these qualities of the setting are sustained. The facilitator needs to be sensitive to moments which create uncertainty and which might adversely affect self-esteem levels in order to intervene immediately and must provide affirmation to what participants are doing as they engage in the stipulated activities of each session.

5.3.3 How did the Dance/Movement Therapy intervention programme influence the participants' self-esteem and subsequent psychosocial well-being?

Participants showed varying levels of development in their self-esteem which could be noted in the following:

- An individual comparison of each participant's pre- and post-intervention scores on the Rosenberg Self-esteem Scale (RSES).
- Development in the range and quality of movement of each participant as well as an increase in the manner in which they employed the space around them during their movement sequences as was indicated on their respective observation schedules.
- Observed improvements in posture, body language, verbalisations and interactions as noted in the process notes of the researcher's diary.
- Reflections on enhanced senses of physical, emotional and social capabilities, acceptance and transcendence of low vision and increased group cohesion in the participants' personal DMT Journey Journals.

Bearing in mind that self-esteem was established as a contributing factor to psychosocial well-being in Chapters 1 and 2 (sections 1.2, 1.3.2 and 2.6.1), an increase in self-esteem implies an improvement in psychosocial well-being; however this was also observed and noted by the various data collection strategies with regard to the psychological and social advances made by participants as the DMT intervention programme progressed.

The DMT intervention programme promoted the above through the following:

- Engaging in physical activity which corrected contorted perceptions of their bodily capabilities as well as the misconstrued body image which it cultivated.
- Addressing the participants' initial low level of self-esteem through therapeutic movement sequences which allowed participants to acknowledge, process, accept and transcend their low vision and its co-morbid physical, psychological and social difficulties.
- Fostering an ability-promoting and accepting environment in which participants could not only experience success, but feel secure enough to act independently and attempt actions and behaviour which they were not sure they could master successfully.
- Cultivating a sense of belonging and being understood by others.
- Presenting opportunities to experience the type of positive social interactions which were the opposite of what they engaged in within their wider social systems.

5.3.4 Problem statement: How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?

As a physical activity, Dance/Movement Therapy addresses the misconstrued perception which learners with low vision hold with regard to their physical capabilities that negatively affects their body image and self-perception. By merely engaging in the physical activity of movement, this perception was already mediated, and by successfully executing the movement sequences which each session posed to them, the learners not only discovered the extent of their physical abilities but developed these aptitudes even further which contributed to an improvement in body image, self-perception and subsequently self-esteem. The increase in participants' sense of independence and control, self-acceptance and self-worth, as well as coping with stressors from their environment, such as academic pressure, which all originated from physically engaging in the presented movement sequences and applying these expressive movement skills outside the DMT setting, also developed their levels of self-esteem which contributed to a greater sense of psychological well-being.

Finally, engaging in physical movement activities within a group context allowed the learners to be part of positive social exchanges, to make meaningful contributions to the self-esteem of other participants and to subsequently alter their perception of the normative feedback which they were used to receiving from their social systems. This did not only add to an improved level of self-esteem, but through their improved self-esteem altered the way in which they engaged with others and subsequently provided them with more positive feedback, which was then assimilated with a more positive self-perception in regard to social capabilities. Thus a greater sense of psychosocial well-being is implied. In conclusion, an improvement in self-esteem through engagement in the physical activity of Dance/Movement Therapy has yielded a greater sense of physical, psychological and social welfare – a positive improvement in psychosocial well-being.

Sections 5.2 and 5.3 are presented on the next page in tabular format in order to present a visual summary of the research findings.

Research questions	Findings from academic literature review	Findings from empirical research	
		Findings from quantitative data	Findings from qualitative data
What will the Dance/Movement Therapy intervention programme entail?	Must be based on a biopsychosocial model within a Systems- and Developmental Theory framework Founded on the principles that communication happens through behaviour, movement reflects personality and that transformation and elaboration of movement will alter thoughts, feelings and interactions Sessions should be structured but must also be adaptable to a certain degree. Music and props can enhance the DMT programme.		DMT programme for adolescents should be designed around the following: The self-perceptions of low vision adolescents Personal strengths and weaknesses and how to use identified strengths to improve on or overcome weaknesses Feedback from micro and macro systems about physical and social abilities, independence, reactions to and interpretations of failure, role models with low vision and future prospects of success.

			Should allow opportunities for familiar progression of activities, collaborative as well as individual movement activities and structured and improvised movement sequences Should be organised yet flexible
How will an accepting environment which promotes ability be established?	Shift from a medical to a biopsychosocial model within a constructivist paradigm Comprehend the sensory impairment of low vision and its psychosocial impact pertaining to the self as well as the person's micro and macro systems The facilitation of transcendence through developing self-esteem and subsequent psychosocial well-being		Follow a familiar structure to create a sense of dependability Implement programme in a group format to facilitate opportunities to relate to others, cultivate a sense of belonging and simulate positive social interactions Include opportunities to experience success and to transcend manageable challenges

			Be sensitive to moments which create uncertainty and which might adversely affect self-esteem levels in order to intervene immediately Provide continuous affirmation
How did the Dance/Movement Therapy intervention programme influence the participants' self-esteem and subsequent psychosocial well-being?	DMT can address disparities in an adolescent with low vision's body awareness and body image through engagement in physical activity It can establish positive social interactions through the communication and comprehension of mutual experiences It can allow for the engagement with thoughts and emotions which might be affecting physical, psychological and/or social welfare	Post-intervention completion of the RSES indicated an improvement in each of the six participants' level of self-esteem to varying extents.	Individual improvement in each participant's pre- and post-intervention scores on the Rosenberg Self-esteem Scale (RSES). Development in range and quality of movement of each participant Increase in use of the space around them Observed improvements in posture, body language, verbalisations and interactions Reflections on enhanced senses

			of physical, emotional and social capabilities, acceptance and transcendence of low vision and increased group cohesion
How does Dance/Movement Therapy as a physical activity influence the psychosocial well-being of six female adolescents with the visual impairment of low vision?	Improved body awareness and image ⇨ Increased self-regard More positive social interactions ⇨ Transcendence of visual impairment ⇨ Improved self-esteem and subsequent psychosocial wellbeing		Address negative perception of physical capabilities ⇨ Improve body image and self-perception ⇨ Increased sense of independence and control improves self-worth ⇨ Increased ability to cope with stressors from micro and macro systems ⇨ Improved social exchanges and increased positive feedback ⇨ Transcendence of visual impairment ⇨ Improved self-esteem and subsequent psychosocial wellbeing

Table 5.1 A summary of research findings through the academic literature review and empirical research process

Due to the limited nature of the empirical research study, a significant number of recommendations cannot be proposed, but the following section will however indicate the two recommendations that can confidently be made.

5.4 RECOMMENDATIONS

The researcher states the following recommendations based on the evidence that taking part in the physical activity of Dance/Movement Therapy provides a beneficial contribution to the self-esteem and subsequent psychosocial well-being of learners with low vision:

- Recommendation 1: This specific school for the visually impaired should create more opportunities to engage in qualitative, focused physical activity than just the two 30 minute Physical Education (PE) periods.
- Recommendation 2: This particular school for the visually impaired should promote family and community education to inform the learner's micro and macro systems of the physical abilities and psychosocial needs of children with low vision so as to address the misconceptions which inform their interactions with these children.

Stemming from the above-mentioned recommendations, opportunities for further research become apparent and are, in the researcher's opinion, considered to be the next plausible step.

5.5 OPPORTUNITIES FOR FURTHER RESEARCH

Further research opportunities include the following:

- Comparative research among other schools for the visually impaired within a South African context with regard to the influence of a Dance/Movement Therapy intervention programme on the self-esteem of learners with low vision could be conducted.
- Larger scale studies need to be conducted in terms of the influence of a Dance/Movement Therapy intervention programme on the self-esteem of learners with low vision in order for findings to be generalised.
- Longitudinal studies which investigate the influence of a Dance/Movement Therapy intervention programme on the self-esteem of learners with low vision will elaborate more on this study's limited conclusions.
- Research can be extended to include the influence of a Dance/Movement Therapy intervention programme on the psychosocial well-being of blind learners and even on learners with hearing impairments within a South African context.

Based on the above, the researcher also needs to acknowledge the limitations to this particular research endeavour.

5.6 LIMITATIONS OF THE STUDY

The fact that the researcher is a novice with regard to conducting research and is still honing her research skills, poses a limitation to this particular study. A further limitation is the limited number of participants (N=6) who participated in the research study which therefore does not make the generalisation of the research conclusions to the wider population possible.

5.7 CONCLUDING REMARKS

This study illustrates the genuine journey of exploring the influence of a Dance/Movement Therapy intervention programme on the psychosocial well-being of learners with low vision. It started with the simple notion that learners with low vision need to engage in physical activity, and that their love for music could be incorporated in order to promote participation in said activities, to progressively reach the decision to study the influence of a DMT intervention programme on the psychosocial well-being of learners at a particular school for the visually impaired in Gauteng. It came about that a DMT intervention programme contributed to the development of self-esteem and the subsequent improvement in psychosocial well-being of these learners through addressing the physical, psychological and social disparities which stemmed from a lack of engaging in physical activities.

Personally, the researcher has been enriched by a deeper understanding of the physical and psychosocial challenges with which learners with low vision deal on a daily basis and has been inspired by their ability to transcend these trials through the healing and promoting effect of dance/movement. The participants' final collaborative movement piece, as well as the joy and freedom with which it was performed, will remain with her long after this study has been completed and will motivate her to provide other learners with low vision with similar opportunities.

LIST OF REFERENCES

Adler, J. 2002. *Offering from the Conscious Body: The Discipline of Authentic Movement*. Rochester: Inner Traditions Bear Company.

Adler, R.H. 2009. Engel's Biopsychosocial Model is still relevant today. *Journal of Psychosomatic Research,* 67(1): 607 – 611. doi:10.1016/j.jpsychores.2009.08.008.

Alpert, P.T. 2011. The Health Benefits of Dance. *Home Health Care Management and Practice,* 23(2): 155 – 157. doi: 10.1177/1684822310384689.

Anderson, H. 2000. Assessment of Sensory Integrative Function in Children and Adolescents with Low Vision. In Stuen, C., Arditi, A., Horowitz, A., Lang, M.A., Rosenthal, B. & Seidman, K.R. (Eds). 2000. *Vision Rehabilitation – Assessment, Intervention and Outcomes*. Netherlands: Swets & Zeitlinger Publishers. pp 398 – 399.

Bakkar, M.M., Alzghoul, E. A. & Haddad, M.F. 2018. Clinical Characteristics and Causes of Visual Impairment in a Low Vision Clinic in Northern Jordan. *Clinical Ophthalmology,* 12(1): 631 – 637. doi 10.2147/OPTH.S153754.

Barstow, B. 2018. Occupational Therapy and Low Vision Rehabilitation: Future Directions. *British Journal of Occupational Therapy,* 81(1): 3 – 4. doi: 10.1177/0308022617738158.

Baxter, P. & Jack, S. 2008. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report,* 13(4): 544 – 559. Available at http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf (accessed on 26 February 2016).

Bertolami, M.D. & Martino, L.A. 2002. Music Therapy in a Private School Setting for Children with Multiple Handicaps who are Visually Impaired or Blind. *Voices – A world Forum for Music Therapy* 2(1).

Blustein, D.L. 2008. The Role of Work in Psychological Health and Wellbeing – A Conceptual, Historical, and Public Policy Perspective. *American Psychological Association*, 63(4): 228–240. doi: 10.1037/0003-066X.63.4.228.

Bradburn, N.M. 1969. *The structure of psychological wellbeing*. Chicago: Aldine Publishing Company.

Brehm, M.A. & McNett, L. 2007. *Creative Dance for Learning: the Kinesthetic Link*. United Kingdom: McGraw Hill.

Brittain, I. 2004. Perceptions of Disability and their Impact upon Involvement in Sport for People with Disabilities at all Levels. *Journal of Sport and Social Issues,* 28(4): 429 – 452. doi: 10.1177/0193723504268729.

Bryl, K. 2018. The Role of Dance/Movement Therapy in the Treatment of Negative Syndrome and Psychosocial Functioning of Patients with Schizophrenia: Results from a Pilot Mixed Method Intervention Study with Explanatory Intent. *Schizophrenia Bulletin*, 44(1): 315 – 316. doi: 10.1093/schbul/sby017.770.

Burmedi, D., Becker, S., Heyl, V., Wahl, H. & Himmelsbach, I. 2002. Emotional and Social Consequences of Age-Related Low Vision. *Visual Impairment Research: The official publication of the International Society for Low-vision Research and Rehabilitation,* 4(1): 47 – 71. doi: 10.1076/vimr.4.1.47.15634.

Caplow-Lindner, E., Harpaz, L. & Samberg, S. 1979. *Therapeutic Dance/Movement: Expressive Activities for Older Adults*. New York: Human Sciences Press.

Carvil, S. 2008. Sensory Impairments, Intellectual Disability and Psychiatry. *Journal of Intellectual Disability Research,* 45(6): 467–483. doi: 10.1046/j.1365-2788.2001.00366.

Chodorow, J. 1999. *Dance Therapy and Depth Psychology: The Moving Imagination*. New York: Routledge.

Choi, H.G., Lee, M.J. & Lee, S. 2018. Visual Impairment and Risk of Depression: A Longitudinal Follow-up Study using a National Sample Cohort. *Scientific Reports,* 8(1): 1 – 8. doi 10.1038/s41598-018-20374-5.

Chaiklin, S. & Wengrower, H. (Eds). 2016. *The Art and Science of Dance Movement Therapy: Life is Dance,* 2nd ed. New York: Routledge.

Cirino, N. 2009. *Bodies in Motion: An Experiential Study of Creative Movement and Yoga with Young Children*. USA: ProQuest LLC.

Cleary, S.E. 2002. Dance Therapy and Sensory Integration: An integrated approach to working with children. Master of Arts in Somatic Psychology: Dance/Movement Therapy, dissertation. Colorado: Naropa University. Available at http://www.dobbse.net/sarah/thesis.pdf (accessed on 18 December 2015).

Connet, D.M. 2011. Total Body Integration: Phenomenological Heuristic Study. Master of Arts in Dance/Movement Therapy and Counseling, dissertation. Chicago: Columbia College.

Cooper, R.A, Quatrano, R.A, Axelson, P.W, Harlan, W, Stineman, M, Franklin, B, Krause, S.J, Bach, J, Chambers, H, Chao, Alexander, M & Painter, P. 1999. Research on Physical Activity and Health among People with Disabilities: A Consensus Statement. *Journal of Rehabilitation Research and Development*, 36(2): 142 – 154. Available at http://search.proquest.com/docview/215294269/fulltextPDF?accountid=14648 (accessed on 11 February 2016).

Corbin, J. & Strauss, A. 2014. Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory, 4th ed. New York: Sage Publications.

Corn, A.L. & Erin, J.N. (Eds). 2010. *Foundations of Low vision – Clinical and Functional Perspectives.* 2nd ed. New York: AFB Press.

Corn, A.L. & Lusk, K.E. 2010. Perspectives on Low Vision. In Corn, A.L. & Erin, J.N. (Eds). 2010. *Foundations of Low Vision – Clinical and Functional Perspectives*, 2nd ed. New York: AFB Press. pp 3 – 34.

Corteville, M.K. 2009. Dance Your Way to Communication: Dance Movement Therapy to Increase Self-Esteem, Poor Body Image, and Communication Skills in High School Females. State University of New York: USA. Master of Science in Education, dissertation. New York: College at Brockport. Available at http://digitalcommons.brockport.edu/edc_theses/21 (accessed on 26 February 2016).

Crandell, J.M. & Robinson, L.W. 2007. *Living with Low Vision and Blindness: Guidelines that Help Professionals and Individuals Understand Vision Impairment*. Illinois: Charles C Thomas Publishers Ltd.

Craven, R.G. & Marsh, H.W. 2008. The centrality of the Self-Concept Construct for Psychological Wellbeing and Unlocking Human Potential: Implications for Child and Educational Psychologists. *Educational & Child Psychology*, 25(2): 104 – 118. Available at http://www.doi.apa.org/?uid=2009-06944-010 (accessed on 2 May 2013).

Creswell, J.W. 2014. Research Design. *Qualitative, Quantitative and Mixed Methods Approaches*. London: Sage Publications Inc.

Cutter, A.C, Shiflett, S.C. & Kuo, D. 2005. Complementary and Alternative Medicine. In De Lisa, J.A. (Ed). 2010. *Physical Medicine and Rehabilitation: Principles and Practice*. 4th ed. Philadelphia: Lippencott, Williams & Wilkins. pp 465 – 478.

David, M. & Sutton, C.D. 2004. *Social Research: The Basics*. London: Sage Publications.

De Fue, M. & Fergusson, K. 2003. Sensory Impairment and Mental Health. *Advances in Psychiatric Treatment*, 9(2): 95 – 103. Available at http://www.apt.rcpsych.org/content/9/2/95.full-text.pdf (accessed on 15 December 2015).

Delgado, M. & Humm-Delgado, D. 2017. The Performing Arts and Empowerment of Youth with Disabilities. *Journal of Research in Social Pedagogy,* 30(1): 105 – 120. doi 10.SE7179/PSRI-2017.30.08.

Devereaux, C. 2014. Moving with the space between us. In Malchiodi, C.A. & Crenshaw, D.A. (Eds). 2014. *Creative Arts and Play Therapy for Attachment Problems*. New York: The Guilford Press. pp 84 – 97.

De Vos, A.S. 2002. Scientific Theory and Professional Research. In Strydom, H, Fouché, C.B. & Delport, C.S.L. (Eds). 2002. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers. pp 28 – 47.

De Vos, A.S. 2002. Qualitative Data Analysis and Interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). 2002. *Research at Grass Roots: For the Social Sciences and Human Services Professions*, 2nd ed. Pretoria: Van Schaik Publishers. pp 339 – 355.

De Vos, A.S., Fouché, C.B. & Venter, L. 2002. Quantitative Data Analysis and Interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). 2002. *Research at Grass Roots: For the Social Sciences and Human Services Professions*, 2nd ed. Pretoria: Van Schaik Publishers. pp 222 – 247.

Dey, I. 1993. *Qualitative Data Analysis: A user-friendly Guide for Social Scientists*. London: Routledge.

Diamond, S. & Lev-Wiesel, R. 2016. Recollections of being in Child Expressive Art Group Therapy: A Qualitative Study of Adult Former Clients' Conceptions of Their Therapy as Children. *International Journal of Group Psychotherapy*, 66(3): 401 – 421. doi: 10.1080/00207284.2016.1149414.

Diener, E. & Chan, M.Y. 2011. Happy People Live Longer: Subjective Well-Being Contributes to Health and Longevity. *Applied Psychology: Health and Well-being,* 3(1): 1 – 43. doi: 10.1111/j.1758-0854.2010.01045.

DiNapoli, J.M., Garcia-Dia, M.J., Garcia-Ona, L., O'Flaherty, D. & Siller, J. 2014. Self-Transcendence Theory. In Fitzpatrick, J.J. & McCarthy, G. (Eds). 2014. *Theories Guiding Nursing Research and Practice: Making Nursing Knowledge Development Explicit*. New York: Springer Publishing Company LLC. pp 251 – 268.

Dogan, T., Totan, T. & Sapmaz, F. 2013. The Role of Self-Esteem, Psychological Well-being, Emotional Self-Efficacy and Affect Balance on Happiness: A Path Model. *European Scientific Journal,* 9(20): 31 – 42. Available at http://www.eujournal.org/index.php/esj/article/download/1559/1565 (accessed on 10 October 2015).

Donald, D., Lazarus, S. & Moolla, N. 2014. *Educational Psychology in Social Context*, 5TH ed. South Africa: Oxford.

Donohue, D. & Borman, J. 2014. The Challenges of Realising Inclusive Education in South Africa. *South African Journal of Education*, 34(2): 1 – 14. Available at http://www.scielo.org.za/pdf/saje/v34n2/03.pdf (accessed on 23 February 2016).

Dunphy, K.F. & Hens, T. 2018. Outcome-focused Dance Movement Therapy Enhanced by Ipad App MARA. *Frontiers in Psychology*, 9(1): 1 – 10. doi: 10.3389/fpsyg.2018.02067.

Duquette, A. 2010. The Effects of a Single Session of Dance/ Movement Therapy with Adults in Crisis Stabilization: A Mixed Methods Study. Master of Arts in Dance/Movement Therapy and Counseling, dissertation. Chicago: Columbia College.

Ebersöhn, L., Eloff, I. & Ferreira, R. 2007. First Steps in Action Research. In Maree, K. (Ed). 2007. *First Steps in Research*. Cape Town: Van Schaik Publishers. pp 124 – 142.

Farrell, M. 2006. *The Effective Teacher's Guide to Sensory Impairment and Physical Disability: Practical Strategies*. New York: Routledge.

Farrell, M. 2009. *The Special Education Handbook: An A-Z Guide*, 4TH ed. New York: Routledge.

Farrely-Hansen, M. 2001. *Spirituality and Art Therapy – Living the Connection*. London: Jessica Kingsley Publishers.

Flick, U. 2009. *An Introduction to Qualitative Research*, 4thed. London: Sage Publication Ltd.

Fouché, C.B. & Delport, C.S.L. 2002. Introduction to the Research Process. In Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). 2002. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers. pp 77 – 92.

Fox, K.R. 1999. The influence of physical activity on mental wellbeing. *Cambridge journals: Public Health Nutrition*, 2(3): 411 – 418. doi: 10.1017/S1368980099567.

Fried, J.P. 2013. Sue and Jon: Working with Blind Children. In Levy, F.J. (Ed). 2013. *Dance and other Expressive Art Therapies: When words are not enough*. New York: Routledge. pp 147 – 166.

Fulmer, C.A., Gelfand, M.J., Kruglanski, A.W., Kim-Prieto, C., Diener, E., Pierro, A. & Higgins, E.T. 2010. On "Feeling Right" in Cultural Contexts: How Person-Culture Match Affects Self-Esteem and Subjective Well-Being. *Association for Psychological Science*, 21(11): 1563–1569. doi: 10.1177/0956797610384742.

George, A.L. & Duquette, C. 2006. The Psychosocial Experiences of a Student with Low Vision. *Journal of Visual Impairment and Blindness,* 100(3): 1 – 22. Available at http://www.*files.eric.ed.gov/fulltext/EJ732709.pdf* (accessed on 15 December 2015).

Gerring, J. 2007. *Case Study Research Principles and Practices*. New York: Cambridge University Press.

Gilbert, C.E. & Ellwein, L.B. 2008. Prevalence and Causes of Functional Low Vision in School-Age Children: Results from Standardized Population Surveys in Asia, Africa, and Latin America. *Investigative Ophthalmology & Visual Science,* 49(3): 877 – 881. doi: 10.1167/iovs.07-0973.

Given, L.M. (Ed). 2008. *The Sage Encyclopaedia of Qualitative Research Methods* – Volumes 1 & 2. California: Sage Publications Incorporated.

Goodill, S.W. 2005. *An Introduction to Medical Dance / Movement Therapy: Health Care in Motion*. London: Jessica Kingsley Publishers.

Goodill, S.W. 2016. Dance/Movement Therapy and the Arts in Healthcare: The First 50 Years. *American Journal of Dance Therapy*. 38(2): 293 – 296. doi: 10.1007s10465-016-9235-z

Goodley, D. & Tragaskis, C. 2006. Storying Disability and Impairment: Retrospective Accounts of Disabled Family Life. *Qualitative Health Research*, 16(5): 630 – 646. doi: 10.1177/1049732305285840.

Goodrich, G.L. & Heubner, K.M. 2010. Low vision – A History in Progress. In Corn, A.L. & Erin, J.N. (Eds). 2010. *Foundations of Low vision – Clinical and Functional Perspectives,* 2nd ed. New York: AFB Press. pp 35 – 66.

Goodwin, P.M. 2008. Sensory Experiences in the Early Childhood Classroom: Teacher's use of Activities, Perceptions of the Importance of Activities and Barriers to Implementation. Master of Science Degree, dissertation. Oklahoma: Oklahoma State University.

Guthold, R., Stevens, G.A., Riley, L.M. & Bull, F.C. 2018. World Wide Trends of Insufficient Physical Activity from 2001 to 2016: A Pooled Analysis of 358 Population-Based Surveys with 1.9 Million Participants. *Lancet Global Health Journal*, 6(10): 1077 – 1086. doi: 10.1016/S2214-109X(18)30357-7

Guthrie, G.P. 2003. *1,600 Quotes and Pieces of Wisdom that Just Might Help You Out When You're Stuck in a Moment (and Can't Get Out Of It).* USA: iUniverse Inc.

Hackney, P. 2002. *Making Connections – Total Body Integration through Bartenieff Fundamentals*. London: Routledge.

Halprin, D. 2003: *The Expressive Body in Life, Art and Therapy: Working with Movement, Metaphor, and Meaning*. London: Jessica Kingsley Publishers.

Hanna, J.L. 1990. Anthropological Perspectives for Dance/Movement Therapy. *American Journal of Dance Therapy,* 12(2): 115-126. doi: 10.1007/BF00843886.

Hannon, F. 2005. Promoting the Participation of People with Disabilities in Physical Activities and Sport in Ireland. *Disability Research Series*, 3(1): 7 – 146. Available at http://www.efds.co.uk/assets/0000/6284/OO111.pdf (accessed on 2 May 2013).

Haun, G. 2009. *Reflections of Helen: An Analysis of the Words and Wisdom of Helen Keller*. Bloomington: Author House.

Hayman, B., Wilkes, L. & Jackson, D. 2012. Journaling: Identification of challenges and reflection on strategies. *Nurse Researcher*, 19(3): 27 – 31. doi 10.7748/nr2012.04.19.3.27.c9056.

Heatherton, T.F. & Wyland, C.L. 2003. Assessing Self-Esteem. In Lopez, E. & Snyder, C.R. (Eds). 2003. *Positive Psychological Assessment: A Handbook of Models and Measures*. Washington DC: American Psychological Association. pp 219 – 233.

Hermann, D. 1999. *Helen Keller – A Life*. Chicago: The University of Chicago Press.

Hooper, S.R. & Umansky, W. 2009. *Young Children with Special Needs*, 5th ed. Columbus Ohio: Pearson Merril Prentice Hall.

Horn, A. 2009. Movement in Gestalt Therapeutic Intervention for Adolescents with Disruptive Behavioural Tendencies. Master of Diaconiology (Direction: Play Therapy), dissertation. Pretoria: University of South Africa. Available http://hdl.handle.net/10500/2004 (accessed on 21 February 2016).

Huurre, T.M. & Aro, H.M. 1998. Psychosocial Development among Adolescents with Visual Impairment. *European Child and Adolescent Psychiatry*, 7: 73-78. doi: 10.1007/s007870050050.

Imrie, R. 1997. Rethinking the relationships between disability, rehabilitation, and society. *Disability and Rehabilitation*, 19(7): 263 – 271. Available at http://www.academia.edu/3639818/Rethinking_the_relationships_between_disability_rehabilitation_and_society (accessed on 15 December 2015).

Inoue, S., Kawashima, M., Hiratsuka, Y., Nakano, T., Tamura, H., Ono, K., Murakami, A., Tsubota, K. & Yamada, M. 2018. Assessment of Physical Inactivity and Locomotor Dysfunction in Adults with Visual Impairment. *National Institutes of Health: Scientific Reports*, 8(1): 1-7. doi: 10.1038/s41598-018-30599-z

Ishtiaq, R., Chaudhary, M.H., Rana, M.A. & Jamil, A.R. 2016: Psychosocial Implications of Blindness and Low Vision in Students of a School for Children with Blindness. *Pakistan Journal of Medical Sciences*, 32(2): 431 – 434. doi: 10.12669/pjms.322.8737

Järvensivu, T. & Törnroos, J. 2010. Case study research with moderate constructionism: Conceptualization and practical illustration. *Industrial Marketing Management*, 39(1): 100 – 108. doi: 10.1016/j.indmarman.2008.05.005.

Johnson, R. 2001. *Elemental Movement: A Somatic Approach to Movement Education*. USA: Dissertation.com.

Johnson, B. & Christensen, L. 2010. *Educational Research: Quantitative, Qualitative and Mixed Approaches,* 4th ed. Los Angeles: Sage Publications.

Jonker, J. & Pennink, B. 2010. *The Essence of Research Methodology: A Concise Guide for Masters and PhD Students in Management Science*. New York: Springer Heidelberg Dordrecht.

Keefe, J. 2005. Psychosocial Impact of Vision Impairment. *International Congress Series*, 12(82): 167 – 173. doi: 10.1016/j.ics.2005.06.005.

Keller, H. 2009. *The Story of My Life: With Her Letters and a Supplementary Account of Her of Her Education. From a 1905 Edition*. Auckland: The Floating Press.

Kidd, L.I. 2010. The Effect of a Poetry Writing Intervention on Self-Transcendence, Resilience, Depressive Symptoms and Subjective Burden in Family Caregivers of Older Adults with Dementia. Doctorate of Philosophy, thesis. Cleveland: Case Western Reserve University.

Killam, L. 2013. *Research Terminology Simplified: Paradigms, Axiology, Ontology, Epistemology, and Methodology*. Sudbury: Laura Killam.

Kirane, K. 2018. Dance/Movement Therapy: A Unique Response to the Opioid Crisis. *American Journal of Dance Therapy*, 40(1): 12 – 17. doi 10.1007/s10465-018-9268-6.

Koch, S.C., Morlinghaus, K. & Fuchs, T. 2007. The Joy of Dance: Specific Effects of a Single Dance Intervention on Psychiatric Patients with Depression. *The Arts in Psychotherapy*, 34(4): 340–349. doi:10.1016/j.aip.2007.07.001.

Koen, V., Van Eeden, C. & Rothman S. 2012. An Exploration of Families' Psychosocial Well-Being in a South African Context. *Journal of Psychology in Africa,* 22(3): 343 – 357. doi:10.1080/14330237.2012.10820539.

Kolcaba, K. 2003. *Comfort Theory and Practice: A Vision for Holistic Health Care and Research*. New York: Springer Publishing Company.

Langton, T.W. 2007. Applying Laban's Movement Framework in Elementary Physical Education. *Journal of Physical Education, Recreation & Dance,* 78(1): 17 – 26. doi: 10.1080/07303084.2007.10597954.

Lansdown, G. 2002. *Disabled Children in South Africa Progress in Implementing the Convention on the Rights of the Child*. Sweden: The International Disability and Human Rights Network. Available at www.daa.org.uk/uploads/pdf/SA%20Childrens%20report%20.pdf (accessed on 2 May 2013).

Laszlo, A. & Krippner, S. 1998. Systems Theories: Their Origins, Foundations and Development. In Jordan, J.S. (Ed). *Systems Theories and a Priori Aspects of Perception*. Amsterdam: Elsevier Science. pp 47 – 74.

Lavendel, F. 2016. Healing into Wholeness: Psychotherapy Practice Informed by the Discipline of Authentic Movement. *Body, Movement and Dance in Psychotherapy*, 12(3): 210 – 221. doi: 10.1080/17432979.2016.1231135.

Law, M., Haight, M., Milroy, B., Willms, D., Stewart, D. &Rosenbaum, P. 1999. Environmental Factors Affecting the Occupations of Children with Physical Disabilities. *Journal of Occupational Science*, 6(3): 102 – 110. doi: 10.1080/14427591.1999.9686455.

Leat, S.J., Legge, G.E. & Bullimore, M.A. 1999. What is Low vision? A re-evaluation of Definitions. *Optometry and Vision Science*, 76(4): 198 – 211. doi: 10.1097/00006324-199904000-00023.

LeFeber, M.M. 2013. Working with children using Dance/Movement Therapy. In Green, E.J. & Drewes, A.A. (Eds). 2013. *Integrating Expressive Arts and Play Therapy with Children and Adolescents.* pp 125 – 148. Available at *https://books.google.co.za/books?isbn=1118775619* / E-Books (accessed on 12 December 2015).

LeFeber, M.M. 2014. Dance/Movement Therapy. In Siri, K. & Lyons, T. (Eds). 2014. *Cutting-Edge Therapies for Autism*, 4th ed. New York: Skyhorse Publishing. pp 463 – 467. Available at https://books.google.co.za/books?isbn=1626367760 / E-Books (accessed on 12 December 2015).

Levy, F.J. 1988. *Dance Movement Therapy – A Healing Art*. Virginia: The American Alliance for Health, Physical Education, Recreation, and Dance.

Lieberman, L.J. & Houston-Wilson, C. 1999. Overcoming the Barriers to Including Students with Visual Impairments and Deaf-Blindness in Physical Education. *American Printing House for the Blind,* 31(3): 129 – 138. Available at http://www.aph.org/pe/articles/overcoming-the-barriers-to-including-students-with-visual-impairments-and-deaf-blindness-in-physical-education/ (accessed on 9 February 2016).

Longmuir, P.E. & Bar-Or, O. 2000. Factors Influencing the Physical Activity Levels of Youths With Physical and Sensory Disabilities. *Adapted Physical Activity Quarterly*, 17: 40 – 53. Available at http://www.journals.humankinetics.com/AcuCustom/Sitename/.../14282.pdf (accessed on 9 October 2015).

Malchiodi, C.A. (Ed). 2012. *Art Therapy and Health Care*. London: The Guilford Press. pp 281 – 290.

Malling, S.H. 2012. Choreography and Performance with Deaf Adults Who Have Mental Illness: Culturally Affirmative Participatory Research. Master of Arts in Dance/Movement Therapy & Counseling, dissertation. Chicago: Columbia College. Available at http://www.digitalcommons.colum.edu/cgi/viewcontent.cgi?article=1029...theses... (accessed on 26 February 2016).

Marais, E. 2012. Bewegingsaktiwiteite as 'n Moontlike Sleutel tot Emosionele en Sosiale Ontwikkeling vir Rolstoelgebonde Leerders. Magister Educationis Inklusiewe Onderwys, verhandeling. Pretoria: University of South Africa. Available at http://www.uir.unisa.ac.za/bitstream/handle/10500/.../dissertation_marais_e.pdf?...1 (accessed on 21 February 2016).

Maree, K. & Pietersen, J. 2007. The Quantitative Research Process. In Maree, K. (Ed). 2007. *First Steps in Research*. Pretoria: Van Schaik Publishers. pp 145 – 153.

Marquès-Brocksopp, L. 2014. Mindfulness, spiritual well-being, and visual impairment: An exploratory study. *British Journal of Visual Impairment,* 32(2): 108 – 123. doi: 10.1177/0264619614528343.

Martins, C. 2014. *Mindfulness-Based Interventions for Older Adults: Evidence for Practice*. London: Jessica Kingsley Publishers.

McCarthy, V. L., Hall, L.A., Crawford, T.N. & Connelly, J. 2017. Facilitating Self-Transcendence: An Intervention to Enhance Wellbeing in Late Life. *Western Journal of Nursing Research*, 40(6): 854 – 873. doi: 10.177/0193945917690731.

McMillan, J.H. & Schumacher, S. 2010. *Research in Education: Evidence-Based Enquiry,* 7th ed. New Jersey: Pearson.

McNutt, J.V. 2012. Art Therapy with Groups and Families: An Open Art Studio Model. In Malchiodi, C.A. (Ed.) 2013. *Art Therapy and Health Care*. New York: The Guilford Press. pp. 281 – 290.

Meekums, B. 2002. *Dance Movement Therapy – Creative Therapies in Practice*. London: Sage Publications.

Meeus, L. 1994. The integration of visual guidance in education and teaching. In Kooijman, A.C., Looijestjin, P.L., Welling, J.A. &Van der Wildt, G.J. (Eds). 1994. *Low vision – Research and New Developments in Rehabilitation*. Oxford: IOS Press. pp 362 – 365.

Mesulam, M. 2002. The Human Frontal Lobes: Transcending the default mode through contingent encoding. In Stuss, D.T. & Knight, R.T. (Eds). 2002. *Principles of Frontal Lobe Function*. New York: Oxford University Press. pp 8 – 30.

Moore, C. & Yamamoto, K. 2012. *Beyond Words: Movement Observation and Analysis*. New York: Routledge.

Morse, J.L. 2004. Psychosocial Aspects of Low Vision. In Josse, R.T. (Ed). 2004. *Understanding Low vision*. New York: AFB Publications. pp 43 – 54.

Moses, T. 2018. Suicide Attempts among Adolescents with Self-Reported Disabilities. *Child Psychiatry and Human Development,* 49(3): 420 – 433. doi 10.1007/s10578-017-0761-9.

Movement Therapy Foundation. 2012. *Types of Movement Therapy: Approaches to Movement Therapy*. Available at http://*www.movementtherapyfoundation.org/MOVEMENT_THERAPY/TYPE* (accessed on 10 October 2013).

Murdoch, H. 2013. *Repetitive Behaviours in Children with Sensory Impairments and Multiple Disabilities*. Deaf Blind International. Available at http://www.deafblindinternational.org/review1_m.html (accessed on 3 February 2015).

Mwamwenda, T.S. 2004. *Educational Psychology: An African Perspective*. Sandton: Heinemann Publishers (Pty) Ltd.

Naidoo, K.S., Jaggernath, J., Ramson, P., Chinanayi, F., Zhuwau, T. & Overland, L. 2015. The prevalence of self-reported vision difficulty in economically disadvantaged regions of South Africa. *African Journal of Disability*, 4(1): 136 – 147. doi: 10.4102/ajod.v4i1.136.

Naipal, S. & Rampersad, N. 2018. A Review of Visual Impairment. *African Vision and Eye Health*, 77(1): 393 – 396. doi: 10.4102/ aveh.v77i1.393.

National Council for Persons with Physical Disabilities in South Africa. 2013. Media Release: Children with Disabilities are Further Disabled by Their Lack of Adequate Care and Education. Available at http://www.NCPPDSA.co.za (accessed on 5 May 2013).

Neff, K.D. 2011. Self-Compassion, Self-Esteem, and Well-Being. *Social and Personality Psychology Compass,* 5(1): 1–12. doi: 10.1111/j.1751-9004.2010.00330.

Newbury, D. 2001. *Diaries and Field Notes in the Research Process*. *Research Issues in Art Design and Media*. Birmingham Institute of Art and Design, University of Central England: The Research Training Initiative.

Newman, B.M. & Newman, P.R. 2014. *Development through life – A psychosocial Approach*, 12th ed. Stanford: Cengage Learning.

Niemann, P. 2002. Psychosocial aspects of Physical Activity. *Pediatric Child Health*, 7(5): 309 – 312.

Nieuwenhuis, J. 2007. Introducing Qualitative Research. In Maree, K. (Eds). *First Steps in Research*. Pretoria: Van Schaik Publishers. pp 47 – 66.

Nolan, P. & Goodill, S.W. 2015. Creative and Expressive Art Therapies, In Micozzi, M.S. (Ed). 2015. *Fundamentals of Complementary and Alternative Medicine*, 5TH ed. Missouri: Elsevier. pp 157 – 174.

Ockelford, A. & Matawa, C. 2010. Focus on Music 2: Exploring the Musicality of Children and Young People with Retinopathy of Prematurity. *British Journal of Special Education,* 37(3): 163 – 164. doi:10.1111/j.1467-8578.2011.00497.

Opie, J. 2018. Educating Students with Vision Impairment Today: Consideration of the expanded Core Curriculum. *British Journal of Visual Impairment,* 36(1): 75 – 89. doi: 10.1177/0264619617730861.

Östlund, U., Kidd, L., Wengströmand, Y. & Rowa-Dewar, N. 2010. Combining qualitative and quantitative research within mixed method research designs: A methodological review. *International Journal of Nursing Studies*, 48: 369 – 383. doi: 10.1016/j.ijnurstu.2010.10.005.

Paradise, A.W. & Kermis, M.H. 2002. Self-esteem and Psychological Well-being: Implications of Fragile Self-esteem. *Journal of Social and Clinical Psychology*, 21: 345 – 361. doi: 10.1521/jscp.21.4.345.22598.

Papadopoulos, K., Montgomery, A.J. & Chronopoulou, E. 2013. The Impact of Visual Impairments in Self-Esteem and Locus of Control. *Research in Developmental Disabilities*, 34: 4565 – 4570. doi: 10.1016/j.ridd.2013.09.036.

Parker, S. 2018. Moving on: An Investigation of Dance/Movement Therapy in PTSD Treatment. *Intuition: The BYU Undergraduate Journal of Psychology*, 13(1): 100 – 111. Available at https://scholarsarchive.byu.edu/cgi/viewcontent.cgi?article=1240&context=intuition (accessed on 2 July 2018).

Payne, H. 2006. *Creative Movement & Dance in Groupwork*. United Kingdom: Speechmark Publishing Ltd.

Pellitterie, J. 2000. Music Therapy in the Special Education Setting. *Journal of Educational and Psychology Consultation*, 11(3&4): 379–391. Available at http://www.*soundconnectionsmt.com/.../Music%20Therapy%20in%20Special%20Ed* (accessed on 2 June 2013).

Pender, N. & Wu, T. 2002. Determinants of Physical Activity among Taiwanese Adolescents: An Application of the Health Promotion Model. *Research in Nursing and Health*, 25: 25 – 35. Available at http://deepblue.lib.umich.edu/bitstream/handle/2027.42/85350/HEALTH_PROMOTION_MANUAL_Rev_5-2011.pdf (accessed on 26 February 2016).

Penedo, F.J. & Dahn, J.R. 2005.Exercise and Well-Being: a Review of Mental and Physical Health Benefits Associated with Physical Activity. *Current Opinion in Psychiatry*, 18 (2): 189 – 193. Available at http://www.ncbi.nlm.nih.gov/pubmed/16639173 (accessed on 22 February 2016).

Petitpas, A.J., Champagne, D.E., Danish, S.J. & Gullotta, T.P. 2000. Developing Competent Youth and Strong Communities through After-School Programming, Sports and Social Competence. *Child Welfare League of America*, 30(6): 115-137. Available at http://www.eric.ed.gov/?id=ED455929 (accessed on 9 October 2013).

Pratt, R.R. 2004. Art, Dance and Music Therapy. *Physical Medicine and Rehabilitation Clinics of North America,* 15(4): 827 – 842. doi: 10.1016/j.pmr.2004.03.004.

Pring, L., Woolf, K. & Tadic, V. 2008. Melody and Pitch Processing in Five Musical Savants with Congenital Blindness. *NCBI Perception,* 37(2): 290 – 307. Available at http://www.ncbi.nlm.nih.gov/pubmed/18456928 (accessed on 8 September 2015).

Prinsloo, E. 2001. Working towards Inclusive Education in South African Classrooms. *South African Journal of Education*, 21(4): 344 – 348. Available at http://www.ajol.info › Journal Home › Vol 21, No 4 (2001) (accessed on 23 February 2016).

Pylvänäinen, P. 2018. Dance Movement Therapy in the Treatment of Depression: Change in Body Image and Mood – A Clinical Practice Based Study. Doctorate in Education, Psychology and Social Research, dissertation. Finland: University of Jyväskylä. Available at http://urn.fi/URN:ISBN:978-951-39-7503-6. (accessed on 15 March 2019).

Regnault, A., Willgoss, T. & Barbic, T. 2018. Towards the Use of Mixed Method Inquiry as Best Practice in Health Outcomes Research. *Journal of Patient-Reported Outcomes*, 2(1): 19 – 22. doi: 10.1186/s41687-018-0043-8.

Resnikoff, D.P., Etya'ale, D., Kocur, I., Pararajasegaram, R., Pokharel, G.P. & Mariotti, S.P. 2004. Global data on visual impairment in the year 2002. *Bulletin of the World Health Organization,* 82(11): 844 – 851. Available at http://*www.ncbi.nlm.nih.gov/pubmed/15640920* (accessed on 26 February 2016).

Reynolds, D. & Reason, M. 2012. *Kinesthetic Empathy in Creative and Cultural Practices*. Chicago: The University of Chicago Press.

Rimmer, J.A. & Rowland, J.L. 2008. Physical Activity for Youth with Disabilities: A Critical Need in an Underserved Population. *Developmental Neurorehabilitation*, 11(2): 141–148. doi: 10.1080/17518420701688649.

Sacks, S.Z. 2010. Psychological and Social Implications of Low vision. In Corn, A.L. & Erin, J.N. (Eds). 2010. *Foundations of Low vision – Clinical and Functional Perspectives,* 2nd ed. New York: AFB Press. pp 67 – 96.

Saldana, J. 2009. The Coding Manual for Qualitative Researchers. London: Sage Publications Ltd.

Salkind, N.J. 2010. Q Methodology in Salkind, N.J. (Eds). 2010. *Encyclopedia of Research Design* Volume 3. London: Sage Publications. pp 1149 – 1182.

Sandel, S.L. & Kelleher, M. 2012. A psychosocial approach to Dance/Movement Therapy, in Sandel, S.L. & Johnson, D.R. (Eds). 2012. *Waiting at the gate – Creativity and Hope in the Nursing Home.* New York: Routledge. pp 25 – 40.

Scheiman, M., Scheiman, M. & Whittaker, S. 2007. *Low Vision Rehabilitation: A Practical Guide for Occupational Therapists*. New Jersey: SLACK Inc.

Schiller, P. 2009. *Seven Skills for School Success: Activities to Develop Social and Emotional Intelligence in Young Children*. Beltsville: Gryphon House Inc.

Schinazi, V.R. 2007. Psychosocial implications of Blindness and Low Vision. *Working Paper Series*. Paper 114. London: University College.

Schmitt, D.P. & Allik, J. 2005. Simultaneous Administration of the Rosenberg Self-Esteem Scale in 53 Nations: Exploring the Universal and Culture-Specific Features of Global Self-Esteem*. Journal of Personality and Social Psychology*, 89(4): 623– 642. doi: 10.1037/0022-3514.89.4.623.

Scheffer, C.N. 2009. Bevordering van Adolesente Dogters se Bewustheid deur middel van Yoga. Magister Diaconiologiae (Spelterapie-Rigting), verhandeling. Pretoria: University of South Africa. Available at http://uir.unisa.ac.za/handle/10500/1484 (accessed on 21 February 2016).

Shennar-Golan, V. & Walteer, O. 2018. Physical Activity Intensity Among Adolescents and Association with Parent-Adolescent Relationship and Well-Being. *American Journal of Men's Health*, 12(5): 1530 – 1540. doi: 10.1177/1557988318768600.

Sinclair, S.J., Blais, M.A., Gansler, D.A., Sandberg, E., Bistis, K. & LoCicero, A. 2010. Psychometric Properties of the Rosenberg Self-Esteem Scale: Overall and Across Demographic Groups Living within the United States. *Evaluations and the Health Professions,* 33(1): 56 – 80. doi: 10.1177/0163278709356187.

Silverman, D. 2013. *Doing Qualitative Research*, 4thed. New York: Sage Publications.

Smart, J. 2011. *Disability across the Developmental Lifespan: For the Rehabilitation Counselor*. New York: Springer Publishing Company.

South Africa. Department of Basic Education. 2011. *CAPS Life Skills Subject Policy Grade 4 – 6.* Available at http://www.education.gov.za/LinkClick.aspx?fileticket=OX12620gNnw%3D&tabid=572&mid=1568 (accessed on 11 February 2016).

South Africa. Department of Education. 2001. *Education White Paper 6: Special Needs Education – Building an Inclusive Education and Training System*. Available at http://www.education.gov.za/LinkClick.aspx?fileticket=gVFccZLi/tI (accessed on 22 February 2016).

South Africa. Department of Health. 2013. *Health Department Calls for more Physical Activity*. Available at www.gov.za/health-department-calls-more-physical-activity. (accessed on 2013/10/29).

Steinberg, L. 2014. *Age of Opportunity: Lessons from the New Science of Adolescence*. New York: Houghton Mifflin Harcourt Publishing Company.

Sticken, J. & Kapperman, G. 2010. Integration of Visual Skills for Independent Living. In Corn, A.L. & Erin, J.N. (Eds). 2010. *Foundations of Low Vision – Clinical and Functional Perspectives*, 2nded. New York: AFB Press. pp 97 – 110.

Strydom, H. 2002. Ethical Aspects of Research in the Social Sciences and Human Service Professions. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). 2002. *Research at Grass Roots: For the Social Sciences and Human Services Professions*, 2nd ed. Pretoria: Van Schaik Publishers. pp Pretoria: 62 – 75.

Strydom, H. & Venter, L. 2002. Sampling & Sampling Methods. In Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). 2002. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers. pp 197 – 209.

Tantia, J.F. 2014. Mindfulness and Dance/Movement Therapy for Treating Trauma. In Rappaport, L. (Ed). 2014. *Mindfulness and the Arts Therapies: Theory and Practice*. London: Jessica Kingsley Publishers. pp 95 – 106.

The Clergy of Christ Episcopal Church. 2010. *The Blessing of a Ginkgo Tree*. USA: Author House.

Tickerhoof George, N.M. 2005. Stress, Psychosocial Factors, and the Outcomes of Anxiety, Depression, and Substance Abuse in Rural Adolescents. Doctorate of Philosophy, thesis. USA: University of Pittsburgh.

Tortora, S. 2006. *The Dancing Dialogue: Using the Communicative Power of Movement with Young Children*. Michigan: Paul H Brookes Publishers.

Trost, S.G. 2006. Public Health and Physical Education. In Kirk, D., MacDonald, D. & O'Sullivan, M. (Eds). 2006. *The Handbook of Physical Education*. London: Sage Publications Ltd. pp 163 – 188.

Tuttle, D.W. & Tuttle, N.R. 2004. *Self-Esteem and Adjusting with Blindness – The Process of Responding to Life's Demands*, 3rd ed. Illinois: Charles C Publishers Ltd.

United States. Department of Health and Human Services. 2008. *Physical Activity Guidelines for Americans*. Centres for Disease Control and Prevention: Washington, DC. Available at http://www.cdc.gov/healthyyouth/physicalactivity/guidelines.htm (accessed on 12 February 2016).

Van der Merwe, S. 2010. The Effect of a Dance and Movement Program on the Perceived Emotional Well-being and Self-Esteem of a Clinical Sample of Adolescents. MA Clinical Psychology, dissertation. Pretoria: University of Pretoria. Available at http://repository.up.ac.za/bitstream/handle/2263/27209/dissertation.pdf?sequence=1 (accessed on 21 May 2013).

Vash, C.L. & Crewe, N.M. 2004. *Psychology of Disability*, 2nd ed. New York: Springer Publishing Company.

Wahl, H.W., Schilling, O., Oswald, F.& Heyl, V. 1999. Psychosocial Consequences of Age-Related Visual Impairment: Comparison with Mobility-Impaired Older Adults and Long-Term Outcome. *Oxford Journals of Medicine, Health&Social Sciences*: *The Journals of Gerontology*, 54(5): 304 – 316. Available at http://www.psychsocgerontology.oxfordjournals.org/content/54B/5/P304.full.pdf (accessed on 9 September 2015).

Wessels-Bloom, S.L. 2008. Dancing For Life: An Exploration of the Effectiveness of Dance Movement Therapy as an Intervention for HIV. Master of Arts in Research Psychology, dissertation. Pretoria: University of Pretoria. Available at https://ujdigispace.uj.ac.za/handle/10210/1684 (accessed on 9 October 2015).

Wolman, B.B. 1998. *Adolescence: Biological and Psychosocial Perspectives*. London: Greenwood Press.

World Health Organization (WHO). 1980. *International classification of impairments, disabilities and handicaps*. Available at http.www.*whqlibdoc.who.int/publications/1980/9241541261_eng.pdf* (accessed on 15 December 2015).

World Health Organization (WHO). 2002. Towards a Common Language for Functioning, Disability and Health – ICF. Available at *www.who.int/classifications/icf/icfbeginnersguide.pdf* (accessed on 5 May 2018).

World Health Organization (WHO). 2007. The International Classification of Functioning, Disability and Health: Children and Youth Version – ICF: CY. Available at *apps.who.int/iris/bitstream/10665/43737/9789241547321_eng.pdf?sequence=1* (accessed on 5 May 2018).

Wong, P.T.P. 2014. Meaning-Seeking, Self-Transcendence, and Well-Being. In Batthyany, A. 2014. *Logotherapy and Existential Analysis: Proceedings of the Viktor Frankl Institute*. New York: Springer.

ANNEXURES

Addendum A: Ethical clearance certificate

UNISA university of south africa

UNISA COLLEGE OF EDUCATION ETHICS REVIEW COMMITTEE

Date: 2018/07/18

Ref: **2018/07/18/49923846/28/MC**
Name: Mrs M Botha
Student: 49923846

Dear Mrs Botha

Decision: Ethics Approval from 2018/07/18 to 2021/07/18

Researcher(s): Name: Mrs M Botha
E-mail address: JufMichelleK@gmail.com
Telephone: +27 82 226 2856

Supervisor(s): Name: Prof. D. Krüger
E-mail address: kruged@unisa.ac.za
Telephone: +27 12 429 4520

Title of research:

Dance/Movement Therapy and the psychosocial well-being of learners with visual impairment: A case study

Qualification: M. Ed in Psychology of Education

Thank you for the application for research ethics clearance by the UNISA College of Education Ethics Review Committee for the above mentioned research. Ethics approval is granted for the period 2018/07/18 to 2021/07/18.

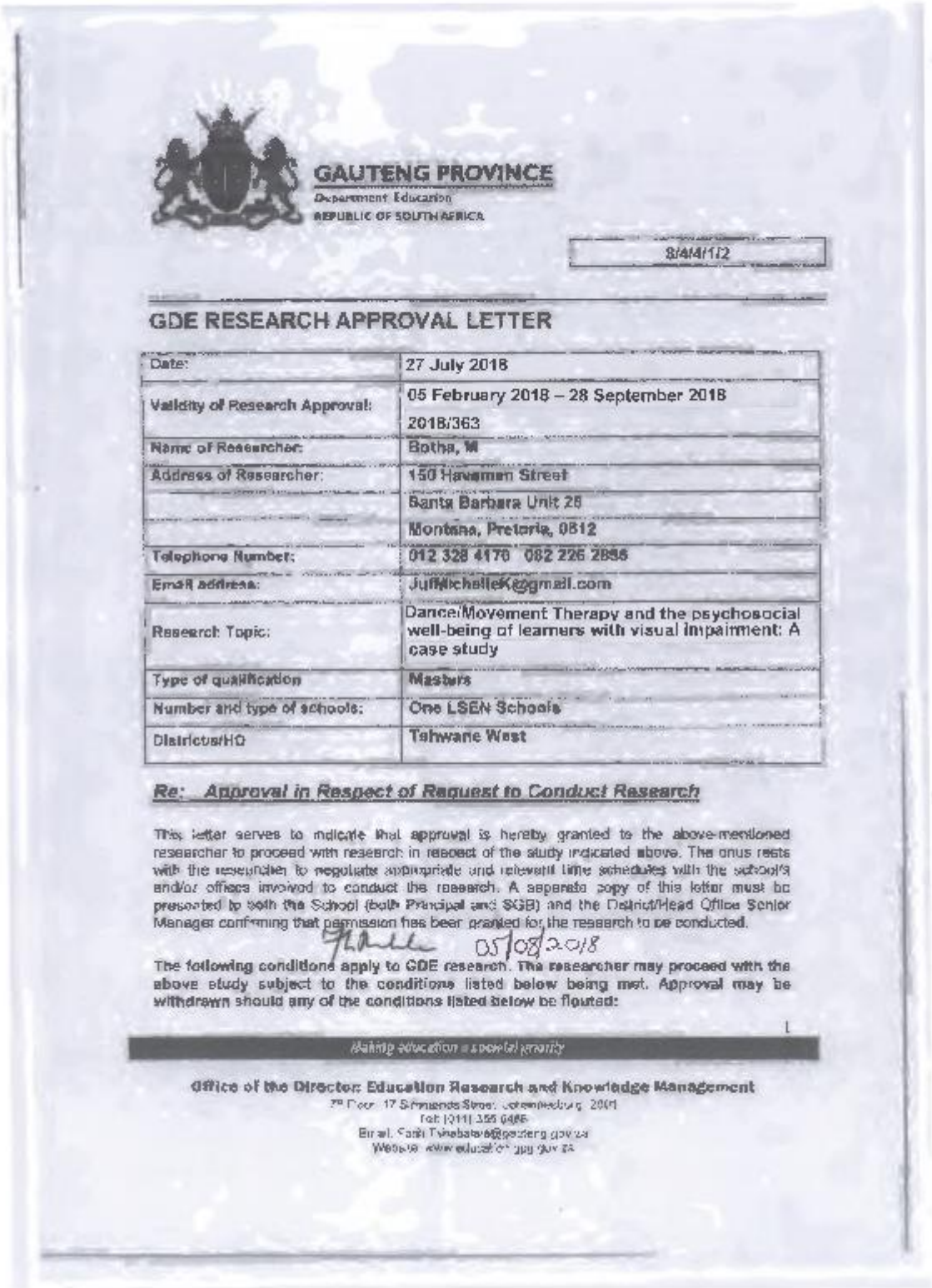
*The **medium risk** application was reviewed by the Ethics Review Committee on 2018/07/18 in compliance with the UNISA Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.*

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the UNISA College of Education Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Addendum B: GDE research approval letter



GAUTENG PROVINCE
Department Education
REPUBLIC OF SOUTH AFRICA

8/4/4/1/2

GDE RESEARCH APPROVAL LETTER

Date:	27 July 2018
Validity of Research Approval:	05 February 2018 – 28 September 2018 2018/363
Name of Researcher:	Botha, M
Address of Researcher:	150 Hawaman Street Santa Barbara Unit 28 Montana, Pretoria, 0812
Telephone Number:	012 328 4170 082 226 2856
Email address:	JuliMichelleK@gmail.com
Research Topic:	Dance/Movement Therapy and the psychosocial well-being of learners with visual impairment: A case study
Type of qualification	Masters
Number and type of schools:	One LSEN Schools
Districts/HO	Tshwane West

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

05/08/2018

The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

1

Making education a apex priority

Office of the Director: Education Research and Knowledge Management
7th Floor 17 Simmonds Street, Johannesburg, 2001
Tel: (011) 355 0488
Email: Faith.Tshabalala@gauteng.gov.za
Website: www.education.gpg.gov.za

Addendum C: Editing certificate

NANETTE J LÖTTER

PROFESSIONAL EDITING AND TRANSLATING

TO WHOM IT MAY CONCERN

This is to certify that the accompanying dissertation submitted in fulfilment of the requirements for a Master's Degree in School Guidance and Counselling and titled: *Dance/movement therapy and the psychosocial well-being of learners with visual impairment: a case study* by Ms Michelle Botha has been electronically edited and is of a suitably high standard in terms of language, syntax and spelling.

Nanette J Lötter
MA (Linguistics and Translation) APEd, APTrans
South African Translators' Institute (Accredited Professional Editor and Translator)
Cell No: 082 2024 244
Email. nanette.lotter@gmail.com

Addendum D: School Governing Body permission letter

MICHELLE BOTHA

B.Soc. Sci (Psychology) (UP); PGCE (Intermediate Phase) (UP); B. Ed Hons. (Educational Psychology) (UP); Endorsement in School Guidance and Counselling (UNISA)

Santa Barbara Unit 28

150 Haveman Street

Montana

0182

Tel: 082 226 2856

Tel: (012) 328 4017 (Office)

Fax: (012) 328 4045

JufMichelleK@gmail.com

Dear Members of the School Governing Body

I am a registered student at the University of South Africa (Unisa), currently completing my second year of the Masters in Educational Psychology with specialisation in School Guidance and Counselling under the supervision of Prof Deirdre Kruger (Tel: 012 429 4520, email: kruged@unisa.ac.za).

By writing this letter, I am requesting permission for some of the school's learners to participate in a research study titled "*Dance/Movement Therapy and the Psychosocial Well-Being of Learners with Visual Impairment: A Case Study.*"

The purpose of this study is to investigate how Dance/Movement Therapy influences the psychosocial well-being of learners with visual impairment.

I would like permission to involve six female participants between the age of 13 and 17 who will be selected according to whether they experience low self-esteem. Grade 6 to 9 Life Skills/Life Orientation educators and the school's auxiliary services will be requested to assist with this identification process to eliminate possible bias from the researcher.

Approximately 10 sessions will be used to collect the required data. These sessions will include 2 sessions to complete a pre- and post-intervention questionnaire and 8 Dance/Movement Therapy (DMT) sessions designed around the participants' needs and progress. The 8 DMT sessions will be video recorded. Data will also be collected through the participants' reflection journals that they complete after each session.

The duration of the respective sessions will be 60 minutes each. These sessions will be scheduled between 14:30 and 15:30 so as to ensure that it does not intervene with the participants' school day or study time and to give them the required time to eat lunch and to relax before their afternoon study session.

Along with your consent, the permission of the School Governing Body, the Department of Education as well Ethical Clearance from the University of South Africa will be obtained.

Parental consent and participant assent will also be gained pending on the approval from the above mentioned institutions. It will be ensured that the consent and assent letters state the rights of the participants, mention possible risks, stipulate procedures to be followed and declare that sessions will be video recorded.

Be assured that participation is voluntary and that the participants may withdraw from the study at any time without reprisal. Confidentiality and anonymity will be upheld at all times and neither the school nor the names of the selected participants will be mentioned in the research study. This will also be stipulated in the consent and assent letters and selected participants will also sign a confidentiality agreement to further ensure secure containment of information gained during the study.

The school principal and SGB, the Department of Education as well as the participants and their parents or guardians will be informed of the findings of this research endeavour through a report which can be emailed or presented in a hard copy. Any enquiries or need for clarification with concern to the findings may then be directed to me in person, in writing or via email.

Should you have any further questions with regards to this request, please do not hesitate to contact me or my supervisor.

Please complete the reply slip as a way of indicating your authorization of the above request.

Thank you for your time and consideration.

Yours sincerely

_____ _____

Michelle Botha Date

REPLY SLIP

We, as members of the School Governing Body of [redacted], herewith give our permission / do not give our permission for Michelle Botha to conduct research at the above mentioned school.

_____ _____

Signature of Chairperson Date

Addendum E: School principal permission letter

MICHELLE BOTHA

B.Soc. Sci (Psychology) (UP); PGCE (Intermediate Phase) (UP); B. Ed Hons. (Educational Psychology) (UP); Endorsement in School Guidance and Counselling (UNISA)

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150 Haveman Street

Montana

0182

Tel: 082 226 2856

Tel: (012) 328 4017 (Office)

Fax: (012) 328 4045

JufMichelleK@gmail.com

Dear Mrs Swart

I am a registered student at the University of South Africa (Unisa), currently completing my second year of the Masters in Educational Psychology with specialisation in School Guidance and Counselling under the supervision of Prof Deirdre Kruger (Tel: 012 429 4520, email: kruged@unisa.ac.za).

By writing this letter, I am requesting permission for some of the school's learners to participate in a research study titled "*Dance/Movement Therapy and the Psychosocial Well-Being of Learners with Visual Impairment: A Case Study.*"

The purpose of this study is to investigate how Dance/Movement Therapy influences the psychosocial well-being of learners with visual impairment.

I would like permission to involve six female participants between the age of 13 and 17 who will be selected according to whether they experience low self-esteem. Grade 6 to 9 Life Skills/Life Orientation educators and the school's auxiliary services will be requested to assist with this identification process to eliminate possible bias from the researcher.

Approximately 10 sessions will be used to collect the required data. These sessions will include 2 sessions to complete a pre- and post-intervention questionnaire and 8 Dance/Movement Therapy (DMT) sessions designed around the participants' needs and progress. The 8 DMT sessions will be video recorded. Data will also be collected through the participants' reflection journals that they complete after each session.

The duration of the respective sessions will be 60 minutes each. These sessions will be scheduled between 14:30 and 15:30 so as to ensure that it does not intervene with the participants' school day or study time and to give them the required time to eat lunch and to relax before their afternoon study session.

Along with your consent, the permission of the School Governing Body, the Department of Education as well Ethical Clearance from the University of South Africa will be obtained.

Parental consent and participant assent will also be gained pending on the approval from the above mentioned institutions. It will be ensured that the consent and assent letters state the rights of the participants, mention possible risks, stipulate procedures to be followed and declare that sessions will be video recorded.

Be assured that participation is voluntary and that the participants may withdraw from the study at any time without reprisal. Confidentiality and anonymity will be upheld at all times and neither the school nor the names of the selected participants will be mentioned in the research study. This will also be stipulated in the consent and assent letters and selected participants will also sign a confidentiality agreement to further ensure secure containment of information gained during the study.

You, the Department of Education as well as the participants and their parents or guardians will be informed of the findings of this research endeavour through a report which can be emailed or presented in a hard copy. Any enquiries or need for clarification with concern to the findings may then be directed to me in person, in writing or via email.

Should you have any further questions with regards to this request, please do not hesitate to contact me or my supervisor.

Please complete the reply slip as a way of indicating your authorization of the above request.

Thank you for your time and consideration.

Yours sincerely

_____ _____

Michelle Botha Date

REPLY SLIP

I, as principal of [redacted], herewith give my permission / do not give my permission for Michelle Botha to conduct research at the above mentioned school.

_____ _____

Signature Date

Addendum F: Parental consent letter

MICHELLE BOTHA

B.Soc. Sci (Psychology) (UP); PGCE (Intermediate Phase) (UP); B. Ed Hons. (Educational Psychology) (UP); Endorsement in School Guidance and Counselling (UNISA)

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150 Haveman Street
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Tel: 082 226 2856
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Fax: (012) 328 4045
JufMichelleK@gmail.com

Dear Parent / Guardian of the prospective participant

I am a registered student at the University of South Africa (Unisa), currently completing my second year of the Masters in Educational Psychology with specialisation in School Guidance and Counselling under the supervision of Prof Deirdré Kruger (Tel: 012 429 4520, email: kruged@unisa.ac.za).

By writing this letter, we are requesting permission for your child, _____ in Grade _____, to participate in a research study titled "*Dance/Movement Therapy and the Psychosocial Well-Being of Learners with Visual Impairment: A Case Study.*"

The purpose of this study is to investigate how Dance/Movement Therapy influences the psychosocial well-being of learners with visual impairment.

Potential benefits can include the increased physical activity of your child by participating in the Dance/Movement Therapy programme. Her participation in this study can also contribute to a better understanding of the effects of Dance/Movement Therapy on the psychological and social wellbeing of adolescent girls with low vision. There will be no payment or gifts involved as an incentive for your child to participate in this study.

Due to the engagement in physical activity during the Dance/Movement Programme, there is the potential risk of physical injury, although every measure, including proper warm up and cool down sessions, will be taken to prevent this from happening. The dance/movement activities are also of such a nature that it does not require your child to be an experienced

dancer. An accommodating and accepting environment will also be ensured so as to prevent any emotional distress or psychological harm during the study.

Your child will take part in 10 sessions over a period of six weeks. These sessions will include 2 sessions to complete a pre- and post-intervention questionnaire and 8 Dance / Movement Therapy (DMT) sessions. The 8 DMT sessions will be video recorded. Your child will also complete a reflection journal after each session which is referred to as a DMT Journey Journal.

The duration of the respective sessions will be 60 minutes each. These sessions will be scheduled between 14:30 and 15:30 so as to ensure that it does not intervene with your child's school day or study time and to give her the required time to eat lunch and to relax before her afternoon study session.

The permission of the school principal, the School Governing Body, the Department of Education as well Ethical Clearance from the University of South Africa has been obtained. Should you require proof of authorisation from any or all of the above, I will gladly provide you with the documentation.

Please note that you are by no means obligated to consent to your child participating in this study. Also be assured that your child's participation is voluntary and that she may decline participation or withdraw from the study at any time without it affecting her academic record or reputation at the school in any manner. Likewise, you are allowed to opt that your child ceases participation in the study at any time, regardless of the fact that you have initially given your permission for her to take part. Do be informed that, should you consent to her participation in this research project, your child will also be requested to provide her assent to take part in the study by signing the assent form which is attached to this letter.

Confidentiality and anonymity will be upheld at all times and neither the school nor the name of your child will be mentioned in the research study. Your child and the other selected participants will also sign a confidentiality agreement to further ensure secure containment of information gained during the study.

Your child's pre- and post-intervention questionnaires as well as her reflections recorded in her personal DMT Journey Journal will be stored in a locked filing cabinet in a secure location for a time period of five years. The video recordings of the 8 Dance Movement Therapy sessions will be stored on a computer as well as an external hard drive which will both be password protected. Potential use of this stored data in future will require additional ethical authorisation. When the five year period has lapsed, the above mentioned hard

copies will be shredded and the video recordings will be permanently deleted from the both the computer and the hard drive by using an applicable software programme.

Both you and your child, the school principal and the school's governing body as well as the Department of Education will be informed of the findings of this research endeavour through a report which can be emailed or presented in a hard copy. Any enquiries or need for clarification with concern to the findings may then be directed to me in person, in writing or via email.

Should you have any further questions with regards to this request, please do not hesitate to contact me or my supervisor.

Please complete the reply slip as a way of indicating your consent for your child to participate in this research study.

Thank you for your time and consideration.

Yours sincerely

_____ _____

Michelle Botha Date

REPLY SLIP

I, parent/guardian of _____ in Grade _____, have read and understood the information stated above and herewith give my permission / do not give my permission for her to participate in this research project.

_____ _____

Signature of parent/guardian Date

Addendum G: Participant assent letter

MICHELLE BOTHA

B.Soc. Sci (Psychology) (UP); PGCE (Intermediate Phase) (UP); B. Ed Hons. (Educational Psychology) (UP); Endorsement in School Guidance and Counselling (UNISA)

Santa Barbara Unit 28 *Tel: 082 226 2856*

150 Haveman Street *Tel: (012) 328 4017 (Office)*

Montana *Fax: (012) 328 4045*

0182 *JufMichelleK@gmail.com*

Dear Learner

I am a teacher currently completing my Master's degree through the University of South Africa (Unisa).

Through this letter, we are inviting you to take part in a study about how Dance / Movement Therapy influences how partially sighted girls between the age of 13 and 17 feel about themselves and their relationships with others.

If you agree to participate in this study, you will take part in 10 sessions over a period of six weeks, along with five of your peers. In the first session you and the other five participants will each complete a few questions which only I will see.

The following 8 sessions will take place twice a week over 4 weeks and will each be an hour long. These sessions will involve dance / movement activities which you and the other five participants will take part in. You do not have to be an experienced dancer to do these activities. Because I will be guiding you and the others through the activities, these sessions will be recorded on video to make sure that I don't miss out on anything. Again, only I will see these videos.

Lastly, after the 8 sessions Dance / Movement Therapy sessions, you and the other five participants will again complete a few questions, which only I will see.

All of the sessions will be scheduled between 14:30 and 15:30 to make sure that it does not influence your school day or study time and to give you enough time to eat lunch and to relax before you have afternoon study.

Please note that you can say yes or no to taking part in this study and no one will offended if you choose not to participate or even if you agree at first, but later on feel that you do not want to take part any more. Saying no or deciding to stop participating anytime during the study will not affect your school work or marks in any way. I will also ask your parent's permission for you to take part in the study.

Your name, the names of the other participants and the name of your school will not be revealed anywhere in my research. You and the other participants will all sign a confidentiality agreement

at the start of the study to make sure that what is shared with the group during the Dance / Movement Therapy sessions stays between me, you and the other members of the group.

Please note that no gifts or prizes will be awarded to you or any other participant for taking part in the study.

You are welcome to ask me any questions you might have before you make your decision to take part or not. Please also speak to your parents or guardian before you decide to participate. Signing the return slip means that you agree to take part in the study (even if you decide to withdraw from the process at a later stage). Also note that a copy of this letter will be given to your parents or guardian.

Regards

Teacher Michelle Botha

REPLY SLIP

Name and surname: _____

Grade: _____ Date: _____

Mark the applicable block with an X:

☐ **YES, I WILL TAKE PART**

☐ **NO, I DON'T WANT TO TAKE PART**

Name of parent: _____

Signature: _____ Date: _____

Name of researcher: _____

Signature: _____ Date: _____

Addendum H: The Rosenberg Self-Esteem Scale

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

Strongly Agree Agree Disagree Strongly Disagree

Scoring:

Items 2, 5, 6, 8, 9 are reverse scored. Give "Strongly Disagree" 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. Sum scores for all ten items. Keep scores on a continuous scale. Higher scores indicate higher self-esteem. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

Addendum I: Observation schedule template

Session: _____Theme: _____Participant: _____

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations						

Addendum J: Researcher's diary template

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: **DATE: _____** **THEME:**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)		**Brainstorming**
Any relation to literature studied? (Incl. references for easy referral) and / or Suggestions about further reading…		

Ideas to follow up on **and / or** **Questions to explore further…**			
Personal views and opinions			
Problem analysis **What was useful (good) / not useful (bad)?**	**Use:**	**Disregard:**	
Any other relevant information			

Addendum K: Dance/Movement Therapy intervention programme

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 2 DATE: _____ THEME: Create Connection & Cohesion

AIM:	○ Hand out DMT Journey Journals ○ Determine group code of conduct ○ Sign confidentiality agreement ○ Corroborate group interrelations and affinity by introducing each participant and identifying a group name through collective movement

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	○ DMT Journey Journal for each participant in large print ○ Stationary (black medium to thick line pens) ○ Confidentiality agreement in large print ○ Hand mirror for each participant

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN	○ Participants each receive their DMT Journey Journal and write their names on the front page ○ Each participant receives a confidentiality agreement ○ The confidentiality agreement is explained by the researcher, signed by each participant and handed back to the researcher ○ Each participant indicates on the second session check in page how she is feeling today	5 MINUTES
DESIGN A CODE OF CONDUCT	○ Participants and researcher suggest rules to guide conduct during the sessions to follow.	10 MINUTES

	○ The rules which are agreed upon by all the participants are written down by the researcher, to be typed and printed in large print for the next session.	
WARM UP	○ Breathing exercises ○ Stretching from head to toe	10 MINUTES
STIMULUS	○ Each participant is handed a mirror and asked to think about what she sees in the mirror and how she feels about what she sees	5 MINUTES
IMPROVISED AND STRUCTURED MOVEMENT	○ Each participant introduces herself through a movement or movement sequence of no more than 4 counts based on the evoked thoughts and feelings from looking in the mirror. ○ Other group members then mirror the same movement in acknowledgement of the mover's thoughts and feelings ○ Participants put movements together to form a group introduction ○ Based on this movement sequence the participants decide on a name for the group with which they all can identify	15 MINUTES
COOL DOWN	○ Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING AND CLOSURE	○ Participants are given the opportunity to reflect on their experience of the session in their DMT Journey Journals ○ Should any participant wish to share her reflection with the rest of the group, she will be given the	10 MINUTES

	opportunity to do so o Session is consolidated o Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	
TOTAL DURATION OF SESSION:		60 MINUTES

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 3 DATE: _____ THEME: Words Shape Me

AIM:	o File copies of confidentiality agreement in each participant's DMT Journey Journals o Hand out group compiled code of conduct to each participant o Each participant is to sign and file the code of conduct in their DMT Journey Journals o Visually displayA3 posters of group name and code of conduct o Express through movement how negative verbal feedback makes each participant feel o Interchanging the expressed negative feedback with positive feedback from other group members through movement

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	o DMT Journey Journal for each participant in large print o Stationary (black medium to thick line pens) o Printed code of conduct for each participant in 18 font o A3 code of conduct to display rules during each session o A3 poster indicating group name also to be displayed during each session o A3 paper for each participant o Coloured medium to thick line pens o Music centre o Music for expressing negative feedback and positive feedback

	respectively

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN	○ Participants are handed their DMT Journey Journals ○ Each participant indicates on the third session check in page how she is feeling today	5 MINUTES
SIGN AND FILE CODE OF CONDUCT	○ Participants are handed a copy of their signed confidentiality agreement and file it in their DMT Journey Journals ○ Participants are each handed a code of conduct ○ Researcher reads the code of conduct out loud ○ Participants sign and file the code of conduct in their DMT Journey Journals	5 MINUTES
DISPLAY OF GROUP NAME AND CODE OF CONDUCT	○ Participants decide where to display the group name and code of conduct ○ Researcher puts up the posters as indicated	5 MINUTES
WARM UP	○ Breathing exercises ○ Stretching from head to toe	10 MINUTES
STIMULUS	○ Each participant reiterates negative feedback which they have recently received out loud ○ Now that it is out there, they “catch” the negative words by writing it down on the A3 paper and drawing any shape around it. ○ Each participant then passes her paper on to the person next to her. ○ Each receiving participant must	5 MINUTES

	then give her presenting participant positive feedback in the form of an affirming statement ○ This statement must be written on the other side of the A4 paper and enclosed in the shape of a heart. ○ Papers are returned to their original owners	
IMPROVISED AND STRUCTURED MOVEMENT	○ Each participant is given the opportunity to form the shape they drew with their body and then execute a movement which breaks that shape, thus letting go of the hurtful feedback ○ To finish the movement sequence the participant then expresses the positive feedback she received through another movement which is completed by creating a shape similar to a heart with her body or any parts thereof. ○ Participants then place their A3 papers showing the affirming words written in the heart shapes all across the floor of the hall ○ They then put the affirming movements of each participant together to from a group movement sequence which is expressed on a self-affirming song across the floor according to the placement of the A3 papers.	15 MINUTES
COOL DOWN	○ Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING AND CLOSURE	○ Participants are given the opportunity to reflect on their experience of the session in their	10 MINUTES

	DMT Journey Journals o Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so o Session is consolidated o Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	
TOTAL DURATION OF SESSION:		60 MINUTES

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 4 **DATE: _____** **THEME: Feeling Feelings**

AIM:	o Review what was done and said during Session 3. o Explore what experiencing failure feels like through tactile stimuli o Explore what experiencing success feels like through tactile stimuli o Render abstract emotions as concrete representations by expressing feelings linked to failure and success through movements which mirror the described tactile stimulus

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	o DMT Journey Journal for each participant in large print o Stationary (black medium to thick line pens) o Various objects with different tactile textures for example sand paper or bark (rough), cotton wool (soft, warm), silk (smooth), clay (squished), lotion on tinfoil (slippery), bubble wrap (bumpy) etc.

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN AND DISPLAY OF GROUP	o Participants are handed their DMT Journey Journals o Each participant indicates on the	5 MINUTES

NAME AND CODE OF CONDUCT	fourth session check in page how she is feeling today o Researcher puts up the posters as a reminder of group cohesion and display of orderly conduct while participants write in their journals	
RECAP	o Researcher consolidates previous session with current session o Participants are given the opportunity to point out anddiscuss whether they thought of or experienced anything relevant to the study between the previous session and now.	5 MINUTES
WARM UP	o Breathing exercises o Stretching from head to toe	10 MINUTES
STIMULUS	o Each participant is handed a selection of objects with different tactile textures. o Each participant must select one texture that represents how she feels when she fails at something as well as a texture that epitomises how she feels when she experiences success.	5 MINUTES
IMPROVISED AND STRUCTURED MOVEMENT	o Each participant must then illustrate a movement sequence between 4 and 8 counts which represents the feeling of the respective textures for example rough and smooth, thus making abstract feelings more concrete. o The six participants then divide into three pairs. o The one participant places the two chosen objects at least ten feet	20 MINUTES

	away from each other and takes position next to the texture that represents her feelings of failure. o She again executes the movements that represent the feelings connected to failure, but then the other participant adds an intervening movement to enter the sequence and move her partner in the opposite direction from which the failure-representing movement was initiated. She then finishes the sequence by doing the movements which represent feelings of success with her partner, thus moving on from failure and affirming a moment of personal triumph. o The same process is then executed with the other partner.	
COOL DOWN	o Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING AND CLOSURE	o Participants are given the opportunity to reflect on their experience of the session in their DMT Journey Journals o Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so o Session is consolidated o Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	10 MINUTES
TOTAL DURATION OF SESSION:		60 MINUTES

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 5 DATE: _____ THEME: Rolling with Role Models

AIM:	○ Review what was done and said during Session 4. ○ Acquaint participants with possible role models with low vision ○ Identify personal traits or experiences of role models with which participants can identify with. ○ Express which traits participants want to aspire to.

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	○ DMT Journey Journal for each participant in large print ○ Stationary (black medium to thick line pens) ○ Short biographies in large print of individuals with low vision who have achieved success by transcending their impairment ○ Music centre ○ Music with themes of overcoming obstacles or achieving success

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN AND DISPLAY OF GROUP NAME AND CODE OF CONDUCT	○ Participants are handed their DMT Journey Journals ○ Each participant indicates on the fifth session check in page how she is feeling today ○ Researcher puts up the posters as a reminder of group cohesion and display of orderly conduct while participants write in their journals	5 MINUTES
RECAP	○ Researcher consolidates previous session with current session ○ Participants are given the opportunity to point out and discuss whether they thought of or experienced anything relevant to	5 MINUTES

	the study between the previous session and now.	
WARM UP AND STIMULUS	○ Participants receive summarized biographies in large print of the following individuals who have transcended their impairment of low vision to achieve success: • Alicia Alonso (dancer) • Mila Kunis (dancer and actress) • Missy Eliot (singer) • Alice Walker (writer) • Thando Hopa (lawyer and model) ○ While the participants are sitting in alternating stretching positions to warm up, the researcher engages in guided reading of the biographies with the participants	15 MINUTES
IMPROVISED AND STRUCTURED MOVEMENT	○ One participant improvises a movement or a movement sequence in a game of movement charades to suggest to the other participants which role model they have chosen to emulate ○ The other participants then get 1 – 2 minutes to deliberate, after which they must present a collaborated structured movement sequence of 4 to 8 counts to communicate to the initial mover which of the character traits of the imitated role model they already see in the initial mover ○ This process is repeated with each of the 6 participants	20 MINUTES

COOL DOWN	○ Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING AND CLOSURE	○ Participants are given the opportunity to reflect on their experience of the session in their DMT Journey Journals ○ Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so ○ Session is consolidated ○ Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	10 MINUTES
TOTAL DURATION OF SESSION:		60 MINUTES

ROLLING WITH ROLL MODELS

ALECIA ALONSO

Alecia Alonso was a professional ballet dancer in the 1930's. In 1941 she was diagnosed with a detached retina. She underwent an operation to fix the problem and had to lie completely still for 3 months. She kept "dancing with her feet" while lying in bed to keep her feet strong.

The operation was not a success and she underwent two more operations where she had to stay in bed, completely motionless for a whole year. Her husband, also a professional dancer, stayed by her bedside and taught her major ballet roles, like Giselle, by only moving her fingers.

In 1943 she was cleared to resume her dancing career and started to rebuild her dancing career despite her limited sight. Within three years she was promoted to the American Ballet Company's principal dancer and danced major roles like Swan Lake.

Although she was partially sighted and had no peripheral vision, she trained her partners to be precisely where she needed them to be. She also asked the set designers to put in bright spotlights in different colours to lead her dance steps.

This helped her to know for example that if she stepped into the shining spotlights close to the front of the stage, she was dancing too close to the orchestra pit. There was also a thin wire placed across the end of the stage at the same height as her waist to show where the stage stopped. Apparently, audiences never new she had low vision while they watched her brilliant performances.

- Edited from Alecia Alonso – Wikipedia; Alecia Alonso, Cuban Dancer – Brittanica.com; Alecia Alonso – Encyclopedia.com

MILA KUNIS

The actress, Mila Kinus, was born in the Ukrain. She immigrated to the United States of America with her parents and older brother when she was only 7. The family arrived in America with $250 and did not understand the culture or the language of this new country. Kunis described this well in her application essay for college: "'Imagine being blind and deaf at age 7."

This was closer to the truth than most people realised because Mila Kunis is blind in one eye due to chronic Iritis which means that the Iris of the eye is constantly inflamed, causing blurred vision, sensitivity to light and even motion sickness.

It is also very obvious to see because this condition usually means that the one eye is a different colour than the other. According to Kunis, bullies loved to tease her about this.

Despite the above, Mila Kunis has had great success as an actress and won an award for best supporting actress for her role in the film Oscar-awarded film "Black Swan" where she played the role of a ballerina and did a lot of the dance work herself.

Her philosophy is: "I love what I do, but I don't need to win…"

- Edited from Mila Kunis – Wikipedia; Mila Kunis, Biography – IMDb

MISSY ELIOT

The 39-year-old rapper and producer has been diagnosed with the auto-immune illness called Grave's Disease.

The disease affects the body on the inside and out causing constant feelings of tiredness, breaking hair, weight loss, shaking and in Missy Elliott's case, Ophthalmopathy, which makes the eyes buldge due to swollen tissue. This leads to light sensitivity, double vision or even vision loss.

There is no cure for this disease, but Missy Eliot is fighting back by undergoing radiation and taking the necessary medication. She also changed her life style by eating healthy and exercising.

She is not ashamed of her eye condition and continues to perform as one of the world's most successful hip hop singers, song writers and producers and has won Grammy awards for best solo female rap performances in 2002, 2003, 2004 and for best music video in 2006.

- Edited from Missy Eliot – Wikipedia

ALICE WALKER

Alice Walker was born in February, 1944 in a rural area. At the age of 8, one of her brothers shot her in the right eye with a BB gun. She became permanently blind in that eye because her family did not have a car and she did not receive the immediate medical attention she needed.

Even though the scar tissue was removed at the age of 14, Walker still has a visible mark in and around the eye, but made peace with this part of her appearance in her essay "Beauty: When the Other Dancer is the Self".

Because she could not play sports like other children, she found enjoyment in reading and writing. In 1961, she was granted a full scholarship by the state of Georgia for having the highest academic achievements of her class and enrolled in college.

Today, she is an American novelist, short story writer, poet, and activist for women's rights. In 1982 she wrote the novel The Color Purple, for which she won the National Book Award for hardcover fiction, and the Pulitzer Prize for Fiction.

- Edited from Alice Walker – Wikipedia

THANDO HOPA

"I'm a black girl who lives in the skin of a white person and that alone should embody what a human being as a whole should represent"

Thando Hopa, is a South African lawyer and part-time fashion model from Johannesburg. She grew up in the shade, hiding her light skin under hats, long sleeves and loads of sunscreen, because she was born with albinism – an inherited depigmentation of the skin. Thando's younger sister was also born with this condition.

Their loving and supportive filmmaker mother and engineer father tried their best to make them feel accepted and not feel self-conscious about their appearance by constantly affirming their beauty and worth. But outside the protection of her family home, she experienced constant bullying, prejudice and misunderstanding.

Superstitious people hugged her out of nowhere because she was seen as a symbol of good luck, while others spat on her because she was considered to be cursed. As she had poor eyesight due to albinism, many teachers mistook her struggle to read and write as having a learning disability.

Thando describes her experience of the outside world as follows:

'My parents had tried hard not to make me feel different but when I went to school kids started acting very awkwardly towards me. They would call me names and as time progressed I noticed people who were older would do things I wouldn't understand. I felt so isolated, it affected me so heavily and I told my mother I wasn't going to school anymore.'

But, with the support of her family, she realised she couldn't let other people's opinions of her hold her back.

She changed her outlook, worked hard to become a lawyer and then gathered up the courage to attempt modelling in the hope that she could change opinions about albinism and challenge conventional ideas of beauty.

Since then she has done many major photo shoots, walked the runway for famous designers and shone on the cover of the first Forbes Life Africa.

Thando explains her decision to become a model by saying: 'I eventually decided beauty is a decision and I am going to be beautiful despite what people say. My tagline now is "a different shade of normal"'.

Edited from Thando Hopa – Forbes Africa

Sources consulted:

https://en.wikipedia.org/wiki/Alicia_Alonso

https://www.britannica.com/biography/Alicia-Alonso

https://www.encyclopedia.com/people/literature-and-arts/dance-biographies/alicia-alonso

https://www.google.co.za/search?ei=2Ag0XIOiA_uE1fAPvZ-nyAM&q=mila+kunis&oq=MILA+KUNIS&gs_l=psy-ab.1.0.0i67l3j0l7.379422.383877..385902...0.0..1.261.1423.2-6.....0....1j2..gws-wiz.....0.G0ahBySWK68#

https://www.google.co.za/search?ei=2Ag0XIOiA_uE1fAPvZ-nyAM&q=mila+kunis&oq=MILA+KUNIS&gs_l=psy-ab.1.0.0i67l3j0l7.379422.383877..385902...0.0..1.261.1423.2-6.....0....1j2..gws-wiz.....0.G0ahBySWK68#

https://www.google.co.za/search?ei=kQo0XIvyCvLGxgPeoYfoBQ&q=MISSY+ELIOT+&oq=MISSY+ELIOT+&gs_l=psy-ab.12..0i10l10.244849.249660..252067...0.0..0.351.1610.2-4j2.....0....1j2..gws-wiz.....0..0j0i67.gs34gFrRE-M#

https://en.wikipedia.org/wiki/Alice_Walker

https://topwomen.co.za/model-prosecutor-poet-thando-hopa-is-fighting-stereotypes-one-campaign-at-a-time/

https://www.forbesafrica.com/woman/2017/11/29/7-questions-thando-hopa/

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 6 **DATE: _____** **THEME: Personal Progress Patterns**

AIM:	○ Review what was done and said during Session 5. ○ Identify a personal weakness as well as a personal strength ○ Identify how to use your personal strength to overcome or work on improving the weakness.

	○ Express this process of personal progress towards self-acceptance through movement

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	○ DMT Journey Journal for each participant in large print ○ Stationary (black medium to thick line pens) ○ A3 paper for each participant ○ Coloured medium to thick line pens ○ Various printed patterns in large print (participants may also create their own patterns)

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN AND DISPLAY OF GROUP NAME AND CODE OF CONDUCT	○ Participants are handed their DMT Journey Journals ○ Each participant indicates on the sixth session check in page how she is feeling today ○ Researcher puts up the posters as a reminder of group cohesion and display of orderly conduct while participants write in their journals	5 MINUTES
RECAP	○ Researcher consolidates previous session with current session ○ Participants are given the opportunity to point out and discuss whether they thought of or experienced anything relevant to the study between the previous session and now.	5 MINUTES
WARM UP	○ Breathing exercises ○ Stretching from head to toe	10 MINUTES
STIMULUS	○ Each participant is instructed to think of a personal weakness as well as a personal strength	5 MINUTES
IMPROVISED AND	○ Each participant must then	20 MINUTES

STRUCTURED MOVEMENT	improvise a movement or sequence of movements not more than 4 counts which illustrates her weakness as well as a movement or series of movements which depicts her strength, which must also not exceed 4 counts. o Each participant is then handed an A3. o They are instructed to draw a symbol for their weakness on the one side or corner of the page and another symbol which represents their strength on the opposite corner or side of the paper. o They are then presented with a series of patterns. o Each participant can then select a pattern or patterns which she feels represents what she needs to do to overcome or improve on her weakness. They may also design their own pattern if they wish to do so. o Each participant then draws the chosen pattern or patterns to close the gap between her weakness and her strength. o Each participant then presents the representing and linking movements as a structured movement piece to express her process towards self-acceptance	
COOL DOWN	o Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING	o Participants are given the opportunity to reflect on their	10 MINUTES

AND CLOSURE	experience of the session in their DMT Journey Journals o Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so o Session is consolidated o Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	
TOTAL DURATION OF SESSION:		60 MINUTES

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 7 DATE: _____ THEME: Holding back or Helping

AIM:	o Review what was done and said during Session 6. o Identify and explore thoughts and emotions associated with feeling dependant on others through group movement activity o Identify and explore thoughts and emotions associated with being supported to be independent through group movement activity o Highlight the importance of communication o Increased understanding of how the above situations affect self-esteem and social relationships

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	o DMT Journey Journal for each participant in large print o Stationary (black medium to thick line pens) o A3 paper for each participant o Music centre o Music as stimulus for movement

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN AND DISPLAY OF GROUP NAME AND CODE OF CONDUCT	○ Participants are handed their DMT Journey Journals ○ Each participant indicates on the seventh session check in page how she is feeling today ○ Researcher puts up the posters as a reminder of group cohesion and display of orderly conduct while participants write in their journals	5 MINUTES
RECAP	○ Researcher consolidates previous session with current session ○ Participants are given the opportunity to point out and discuss whether they thought of or experienced anything relevant to the study between the previous session and now.	5 MINUTES
WARM UP	○ Breathing exercises ○ Stretching from head to toe	10 MINUTES
STIMULUS AND IMPROVISED MOVEMENT	○ Participants are divided into two groups of three. ○ Two of the participants are instructed to hold onto the third participant's arms and legs and to try and move in sync with the middle participant's improvised movements ○ Music starts to play and the middle participant is instructed to attempt to improvise movement to the music ○ The same procedure is repeated alternately with the other two participants of each group	10 MINUTES
STIMULUS	○ The initial stimulus movement	15 MINUTES

AND STRUCTURED MOVEMENT	exercise is now repeated, but this time the middle participant tells the other two participants on either side what she intends to do and what she needs them to do to allow her to express herself through structured movement to the same musical stimulus o The exercise must now end in a pose where the middle participant's body is completely supported by the other two participants o The same process is then repeated with the other two participants as well	
COOL DOWN	o Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING AND CLOSURE	o Participants are given the opportunity to reflect on their experience of the session in their DMT Journey Journals o Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so o Session is consolidated o Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	10 MINUTES
TOTAL DURATION OF SESSION:		60 MINUTES

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 8 DATE: _____ THEME: From Small to Tall

AIM:	○ Review what was done and said during Session 7. ○ Encourage exploration and use of space and levels ○ Consolidate content and experiences from previous sessions in preparation for final or termination session ○ Reflect on each participant's DMT journey thus far ○ Express and share thoughts and feelings through movement method of story telling

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	○ DMT Journey Journal for each participant in large print ○ Stationary (black medium to thick line pens) ○ Words or themes which were evident or distinct in previous sessions, printed in 48 font inside speech bubbles (a set for each participant) ○ Scissors ○ Glue / prestick ○ Music centre ○ A collaboration of all music used in previous sessions

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN AND DISPLAY OF GROUP NAME AND CODE OF CONDUCT	○ Participants are handed their DMT Journey Journals ○ Each participant indicates on the eighth session check in page how she is feeling today ○ Researcher puts up the posters as a reminder of group cohesion and display of orderly conduct while participants write in their journals	5 MINUTES
RECAP	○ Researcher consolidates previous	5 MINUTES

	session with current session ○ Participants are given the opportunity to point out and discuss whether they thought of or experienced anything relevant to the study between the previous session and now.	
WARM UP	○ Stretching from head to toe	5 MINUTES
STIMULUS AND IMPROVISED MOVEMENT	○ Each participant receives one of six cards, which when opened respectively contains the following words: small/big & wide/narrow; short/tall & broad/confined; flat/raised & thick/thin; crawl/fly & spacious/cramped; low/high & open/closed; sink/float& expanded/contracted ○ The moment the card is opened each dancer must improvise movement which illustrates all four words to experiment with using different levels and degrees of space	5 MINUTES
STIMULUS AND STRUCTURED MOVEMENT	○ Participants are each given their set of words and given time to read them and cut out the various speech bubbles ○ They must then sort these words according to which they consider to be disabling and enabling and paste them on their A3 paper to create a structured movement story between 8 and 16 counts through which she tells about her journey from the disabling words expressed through lower, smaller	25 MINUTES

	and constricted movements towards the enabling words expressed through extended, expanded and larger movements o Each participant is then given the opportunity to tell her story of how she removed the “dis” from “disability” through her movement piece.	
COOL DOWN	o Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION SHARING AND CLOSURE	o Participants are given the opportunity to reflect on their experience of the session in their DMT Journey Journals o Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so o Session is consolidated o Session is ended with a bow/curtsy to show positive regard and appreciation for each participant	10 MINUTES
TOTAL DURATION OF SESSION:		60 MINUTES

DANCE / MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 9 DATE: _____ THEME: Salute to Self-Worth

AIM:	o Review what was done and said during Session 8. o Affirm self-worth through reading and creating a movement piece to a poem about self-worth o Celebrate each participant for what she contributed to the programme o Consolidate and terminate programme

SPACE:	The primary section's school hall, which is reserved specifically for use by smaller groups.
MATERIALS:	○ DMT Journey Journal for each participant in large print ○ Stationary (black medium to thick line pens) ○ Poem about self-esteem ○ Affirmation cards with each participant's strengths which contributed to the programme ○ Music centre ○ "Who says" by Selena Gomez ○ The poem "Invictus"

SESSION SEGMENT	DESCRIPTION OF ACTIVITY	DURATION
CHECK IN AND DISPLAY OF GROUP NAME AND CODE OF CONDUCT	○ Participants are handed their DMT Journey Journals ○ Each participant indicates on the ninth session check in page how she is feeling today ○ Researcher puts up the posters as a reminder of group cohesion and display of orderly conduct while participants write in their journals	5 MINUTES
RECAP	○ Researcher consolidates previous sessions with current session ○ Participants are given the opportunity to point out and discuss whether they thought of or experienced anything relevant to the study between the previous session and now.	5 MINUTES
WARM UP	○ Stretching from head to toe	5 MINUTES
STIMULUS AND IMPROVISED MOVEMENT	○ The researcher reads 4 lines of the adapted poem "I love being me" to each respective participant ○ Each participant must then improvise a movement sequence	5 MINUTES

	between 4 and 8 counts to illustrate their 4 lines of the poem	
STIMULUS AND STRUCTURED MOVEMENT	○ The researcher reads the adapted poem “I love being me” as a whole. ○ The six participants illustrate their individual movement sequence to each other and integrate their movements to create a self-affirming group movement piece. ○ The researcher then reads the adapted poem rhythmically while the group perform their collective movement piece	15 MINUTES
COOL DOWN	○ Breathing and stretching exercises	5 MINUTES
PROCESSING, REFLECTION AND SHARING	○ Participants are given the opportunity to reflect on their experience of the session in their DMT Journey Journals ○ Should any participant wish to share her reflection with the rest of the group, she will be given the opportunity to do so	10 MINUTES
TERMINATION OF SESSION	○ Each participant is called forward while the researcher reads out the strengths she contributed to the programme from the affirmation card which is then handed to the participant (similar to a graduation ceremony) ○ The group then stands in a circular formation ○ The song “Who says” by Selena Gomez is played and the participants, along with the researcher, freestyle to the song, giving each member a chance to	10 MINUTES

	dance in the middle if she wishes to do so ○ The researcher terminates the programme with the reading of the poem “Invictus” ○ Session is ended with a bow/curtsy to show positive regard and appreciation for each participant but a salute movement is added at the end to finalize the end of this Dance / Movement Intervention Programme	
TOTAL DURATION OF SESSION:		60 MINUTES

I Love Being Me

I write in big letters
I have to squint to see
I can't read the quickest
but I love being me

What you can see from afar
I need to see closely
I learn with a magnifying glass
but I still love being me

You see, this is my life
as others would see
they don't know what it's like
to really be me

So next time I'm about
walking unsurely down the street
don't think of me as impaired
but someone cool to meet

I have lots I can teach you
I have loads I can share
you will never gain my wisdom
if you just point and stare

So maybe I can't read the fastest
maybe I can't see something small
but I wouldn't change being me
not for you, not at al

by Gemma Hayton

(Adapted for learners with low vision by M Botha)

Invictus

Out of the night that covers me,
Black as the pit from pole to pole,
I thank whatever God may be,
For my unconquerable soul.

In the fell clutch of circumstance,
I have not cried nor winced aloud,
Under the bludgeoning of chance,
My head is bloody but unbowed.

Beyond this place of wrath and tears
Looms but the horror of the shade,
And yet the menace of the years
Finds and shall find me unafraid.

It matters not how straight the gate,
How charged with punishments the scroll,
I am the captain of my fate,
I am the master of my soul.

by William Earnest Henley

SONG SELECTION FOR DANCE / MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

- BEAUTIFUL – CHRISTINA AGUILERA
- BETTER WHEN I'M DANCING – MEGAN TRAINOR
- BORN THIS WAY – LADY GAGA
- BRAVE – SARA BAREILLES
- CONFIDENT – DEMI LEVATO
- FIGHTER – CHRISTINA AGUILERA
- FIGHT SONG – RACHEL PLATTEN
- I LOVE ME – MEGAN TRAINOR
- JUST THE WAY YOU ARE – BRUNO MARS
- LEGACY – NICOLE NORDEMAN
- LOVE MYSELF – HAILEE STEINFELD
- MASTER PIECE – JESSE J
- ME TOO – MEGAN TRAINOR
- ONE STEP AT A TIME – JORDAN SPARKS
- PERFECT – PINK
- RISE – KATY PERRY
- RUN THE WORLD – BEYONCE
- SHAKE IT OFF – TAYLOR SWIFT
- SKY SCRAPER – DEMI LEVATO
- STRONGER – BRITNEY SPEARS

- STRONGER – KELLY CLARKSON
- THE CLIMB – MILEY CYRUS
- THE VOICE WITHIN – CHRISTINA AGUILERA
- THIS IS MY NOW – JORDAN SPARKS
- WHO SAYS – SELENA GOMEZ

Sources consulted:

https://www.ellenbailey.com/poems/ellen_365.htm

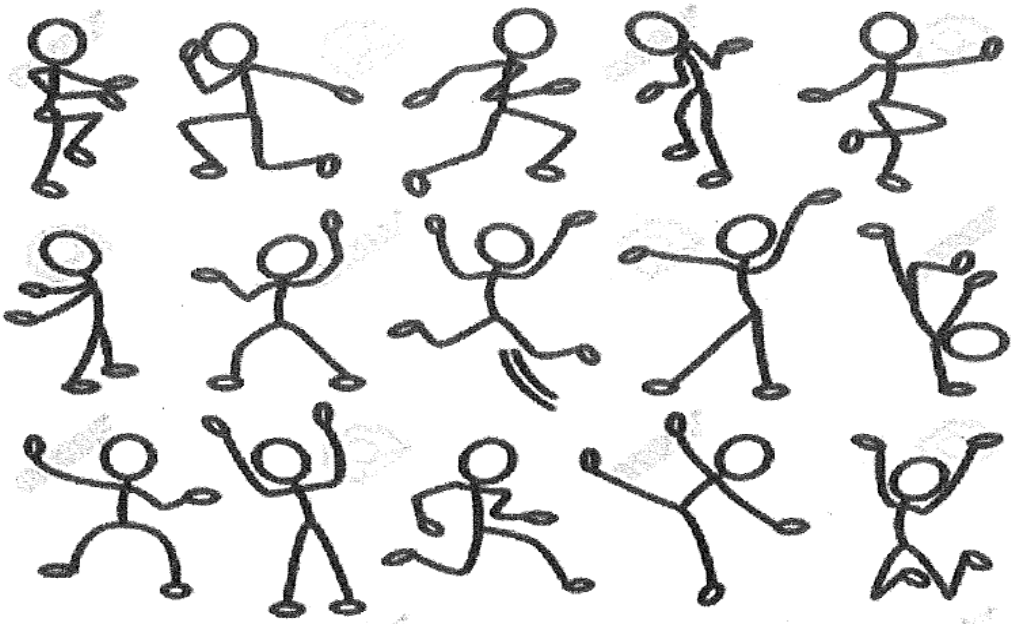
https://www.poetryfoundation.org/poems/51642/invictus

https://www.bustle.com/articles/194279-32-self-care-songs-for-when-your-confidence-just-needs-a-pick-me-up

https://www.billboard.com/articles/news/pride/8013886/25-empowerment-anthems-songs-extra-boost-confidence

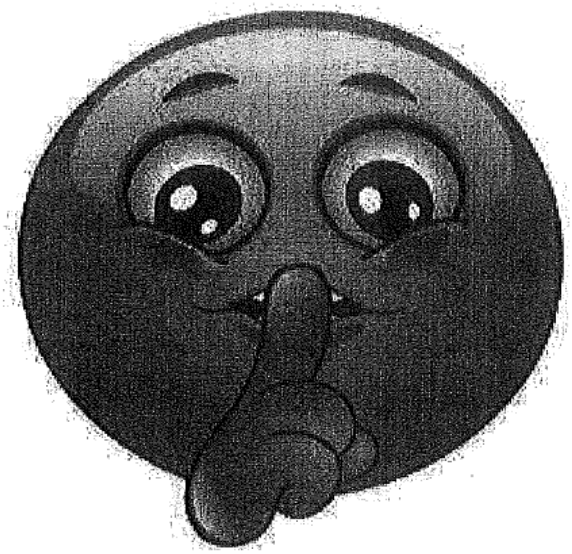
Addendum L: Example of a Personal DMT Journey Journal

MY DANCE / MOVEMENT THERAPY JOURNAL

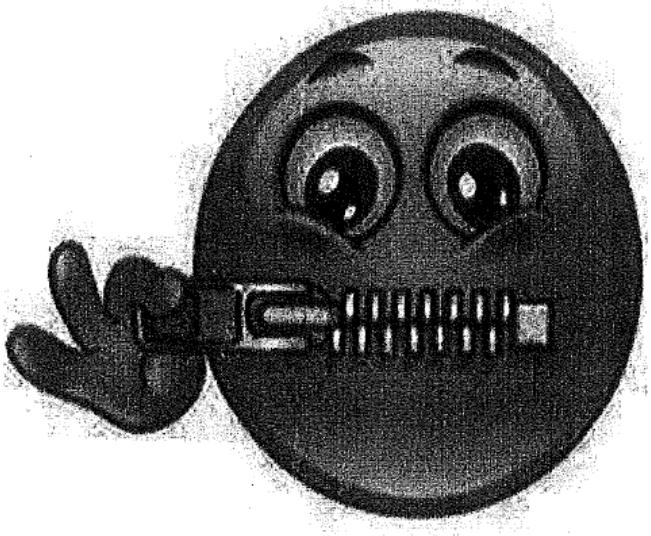


NAME: [redacted]

[redacted]



CONFIDENTIALITY AGREEMENT



PARTICIPANT D

CONFIDENTIALITY AGREEMENT

(Insert Group Name)

STARLIGHT MIX

PLEDGE OF CONFIDENTIALITY

This is to certify that I, [redacted],

a participant in this Dance / Movement Therapy Programme understand that any information (written, verbal or other form) obtained during the Dance / Movement Therapy sessions must remain confidential and must not be shared with anyone outside of this group.

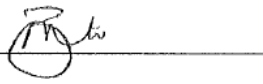
This includes all information about myself, my fellow group members and our facilitator or any other information which I, my fellow group members or our facilitator might share through words, movements or in the DMT Journey Journals.

I understand that sharing this information outside of the Dance / Movement Therapy group can affect the feeling of trust between myself and my fellow group members and may be hurtful to one, more or all of them.

I thereby pledge to safeguard the trust my fellow group members have handed to me with the utmost care.

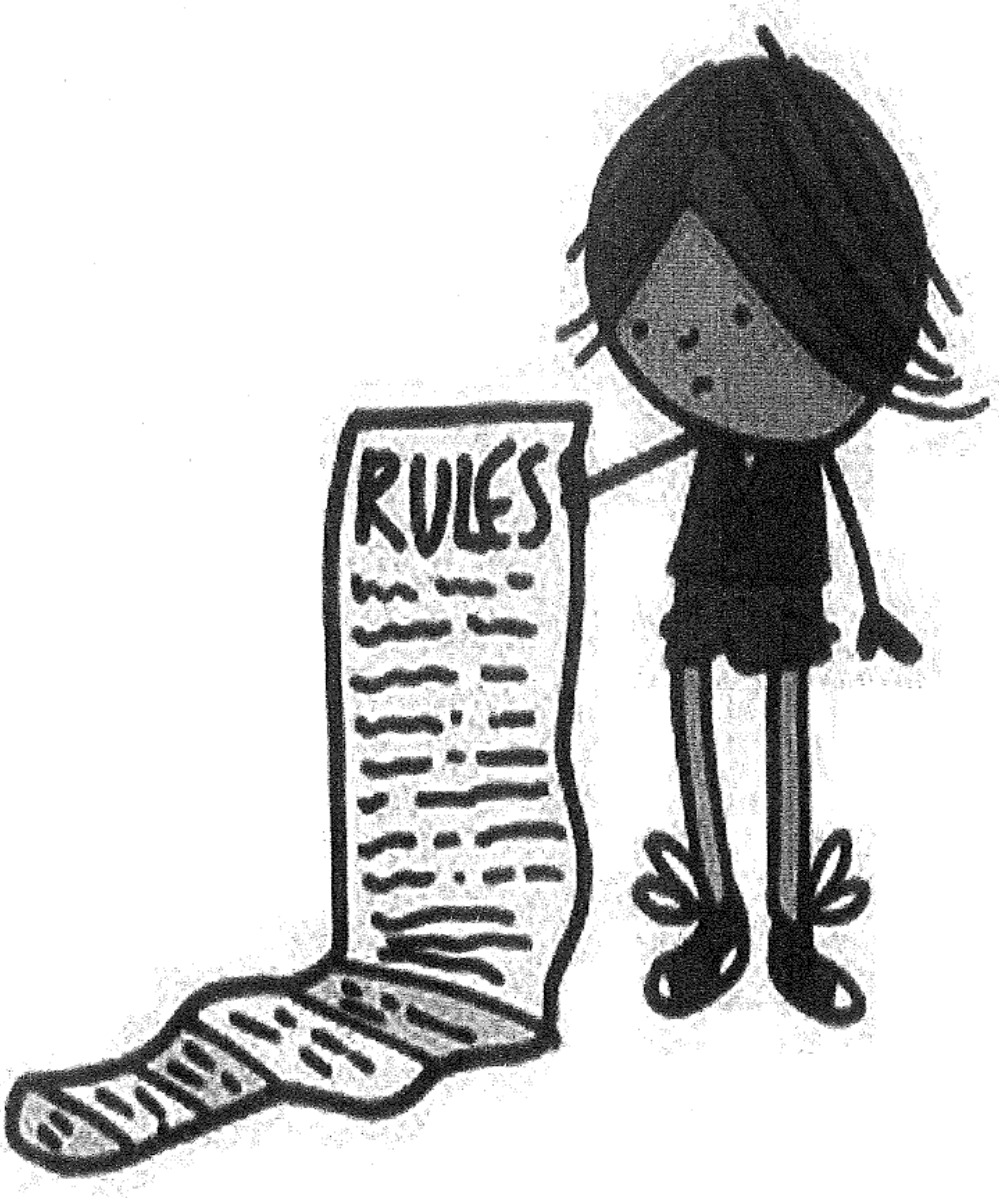
[redacted] 2018-21-08

Signature Date

 2018/08/21

Signature of researcher as witness Date

CODE OF CONDUCT



STARLIGHT MIX CODE OF CONDUCT

1. WE MAY NOT JUDGE EACH OTHER
2. WE MUST ALWAYS ACT AND SPEAK WITH LOVE AND KINDNESS
3. WE MUST BUILD EACH OTHER UP; NOT BREAK EACH OTHER DOWN
4. BE ON TIME
5. WE MAY NOT LAUGH AT EACH OTHER – WE ONLY LAUGH TOGETHER
6. WE MUST RESPECT EACH OTHER DURING AND ALSO AFTER EACH SESSION
7. WHAT IS SAID OR EXPRESSED IN THE GROUP STAYS IN THE GROUP
8. ALWAYS BE YOURSELF
9. WE WILL NOT ACT LIKE WE ARE BETTER THAN ANY ONE ELSE IN THE GROUP
10. WE WILL RESPECT OUR FASCILITATOR
11. WE WILL NOT DISCUSS EACH OTHER WITH ONE ANOTHER OR WITH ANY ONE ELSE OUTSIDE THE GROUP
12. WE WILL DRESS APPROPRIATELY

13. WE MUST BELIEVE IN OURSELVES

14. ITS OKAY TO FEEL

15. WE WILL ALWAYS ADDRESS EACH OTHER WITH RESPECT

16. DON'T BE A BULLY

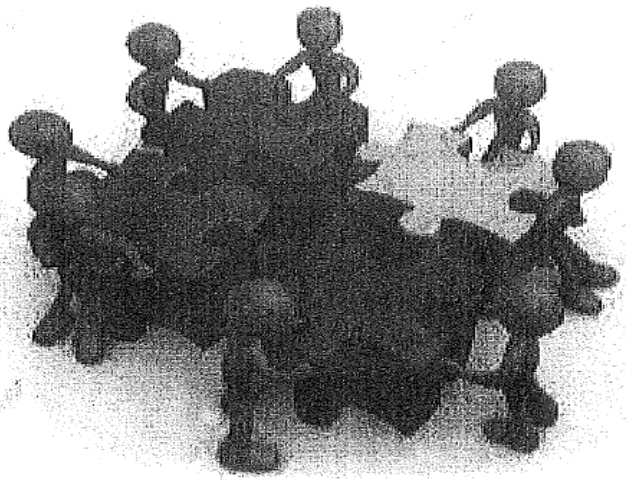
17. LOVE YOURSELF AND EACH OTHER

[redacted] [redacted]

NAME SIGNATURE

2018-23-08.

DATE

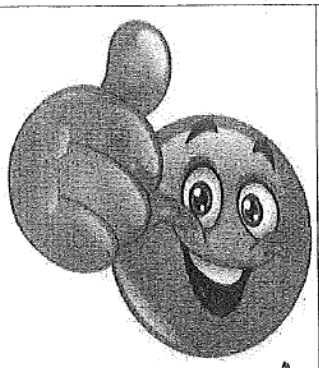
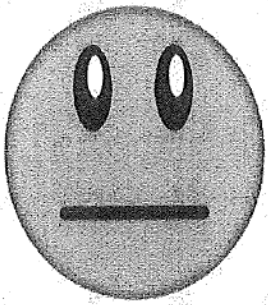
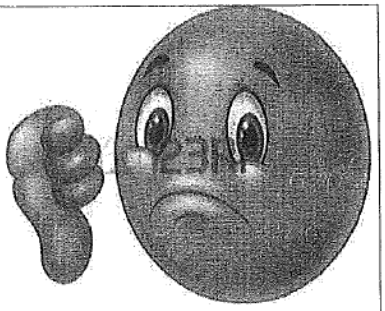
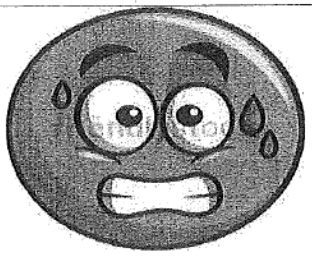
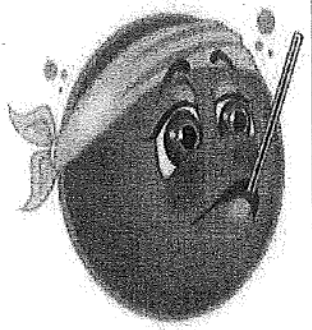
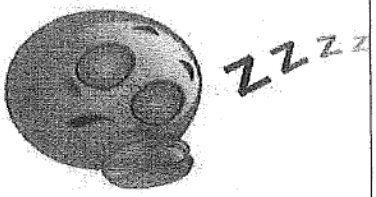


SESSION 2:

CREATE CONNECTION AND COHESION

SESSION 2 CHECK IN:

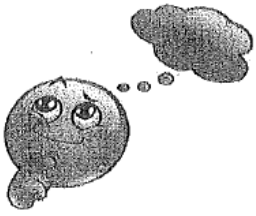
DATE: 21 August 2018

		
GOOD	**OKAY**	**BAD**
		
NERVOUS ✓	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

I am feeling nervous because I am not use to sharing feelings with any other person besides my cousin



REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

When we combined the moves and we did the dances together.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

No there were not.

WHAT DID I DISCOVER ABOUT MYSELF?

I can do things if I try to be confident

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

When we had to ~~d~~ make our own moves and do them infront of eachother.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

I have only one thought that what if the other group members do not accept me when we are somewhere else.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They did not laugh and were really positive about my move.

HOW DID I HELP OTHERS DURING THIS SESSION?

I accepted their moves and I enjoyed them.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

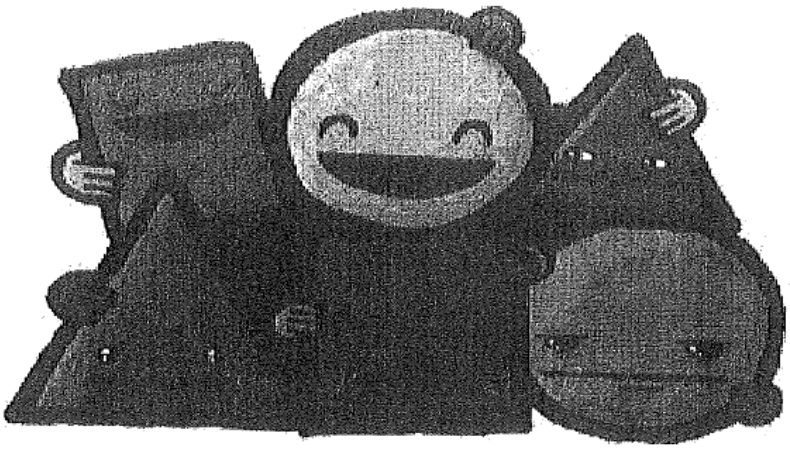
~~I fe~~ My strength was that I am becoming confident.

IS THERE ANYTHING I CAN IMPROVE ON?

Nothing at all.

HOW AM I FEELING NOW?

I feel good, excited ~~am~~ and I want to be open.

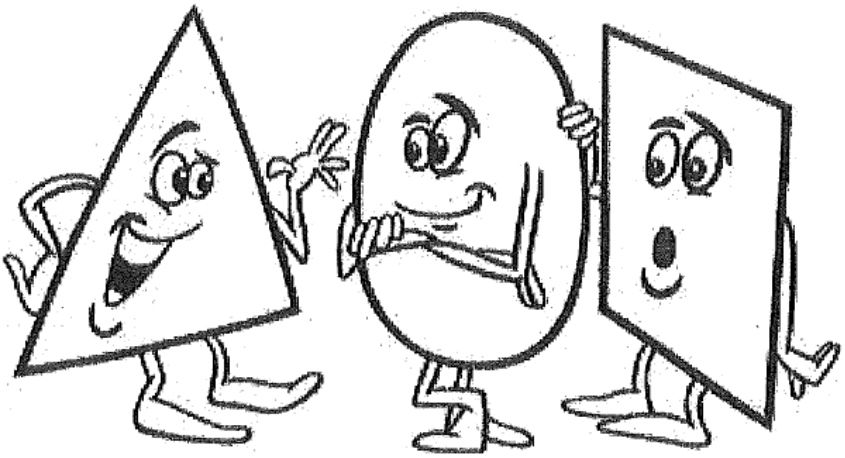


SESSION 3:

WORDS

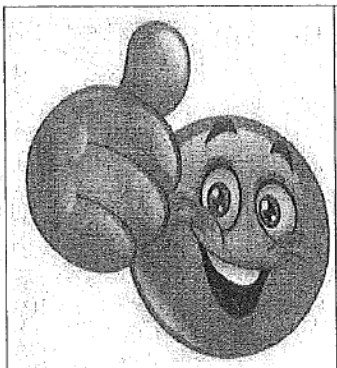
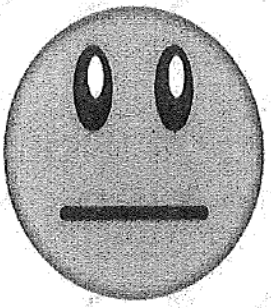
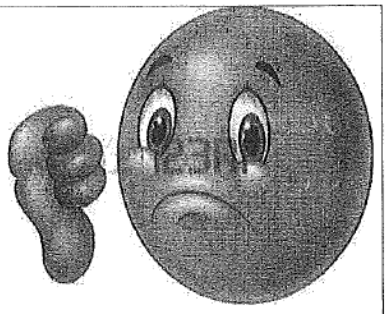
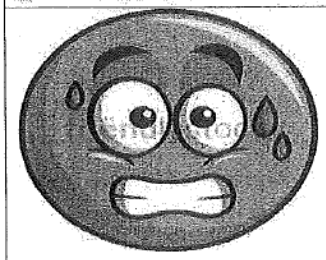
SHAPE

ME



SESSION 3 CHECK IN:

DATE: 23 August 2018

		
GOOD	**OKAY**	**BAD**
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

I am really happy and I can't wait to see what we are going to do after a wonderful day.

REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

When we combined the dances.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

None.

WHAT DID I DISCOVER ABOUT MYSELF?

I can do it if I believe.

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

When we had to a show everyone our moves.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

None because normally I am worried about my body and I was motivated to feel better.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They did not be mean or laugh at me and just accepted me.

HOW DID I HELP OTHERS DURING THIS SESSION?

I Laughed with everyone.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

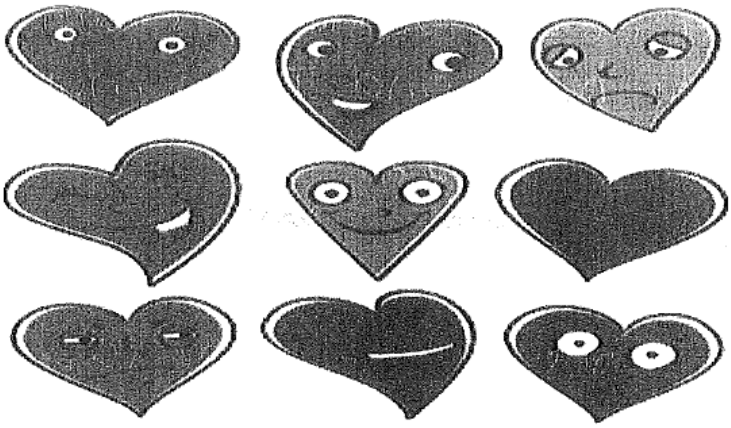
When I was open about the most hurtful thing I heard.

IS THERE ANYTHING I CAN IMPROVE ON?

Being more open and confident.

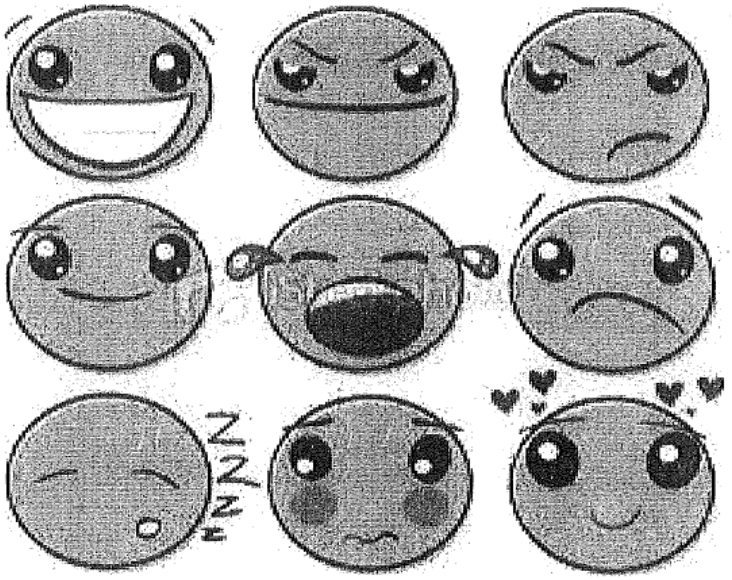
HOW AM I FEELING NOW?

I feeling much more better.



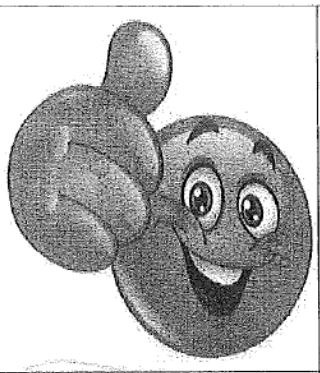
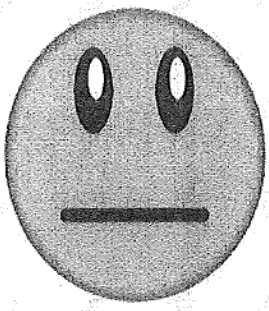
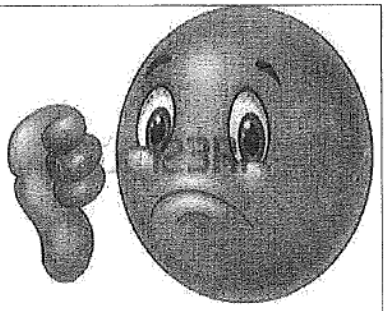
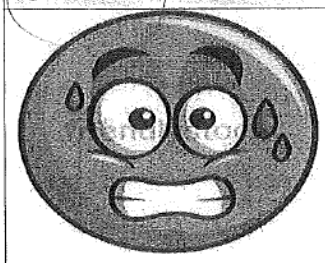
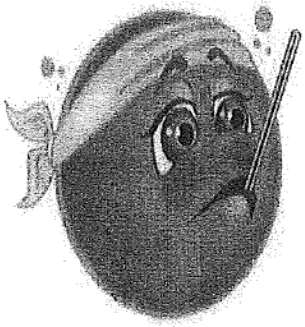
SESSION 4:

FEELING FEELINGS



SESSION 4 CHECK IN:

DATE: 28 August 2018

		
GOOD	**OKAY**	**BAD**
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

Today is the day after my birthday. Its also my grandfathers birthday and I got a big piece of chocolate from someone I did not actually know I existed.

REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

When we worked together in groups.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

I did not like seeing one of the group members blue.

WHAT DID I DISCOVER ABOUT MYSELF?

Nothing.

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

When we had to show our moves to other people.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

I still don't accept myself.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They did not judge me and helped me with my moves.

HOW DID I HELP OTHERS DURING THIS SESSION?

I helped them with their moves.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

None.

IS THERE ANYTHING I CAN IMPROVE ON?

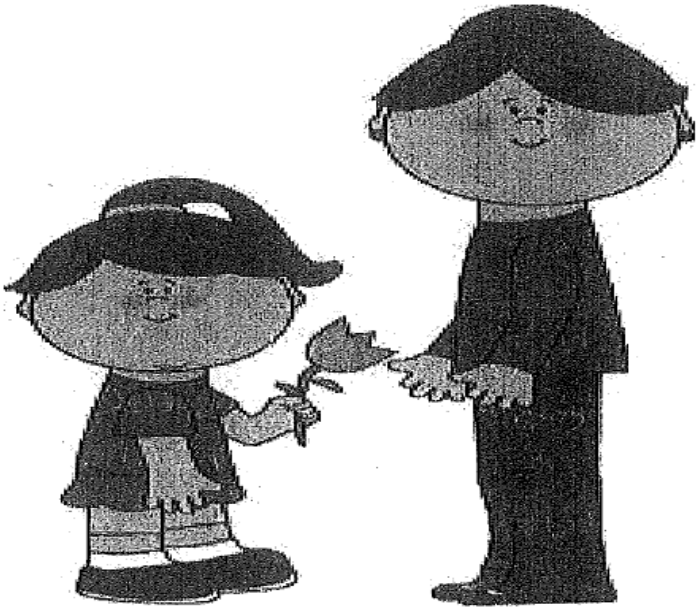
Nothing.

HOW AM I FEELING NOW?

Still feel good.

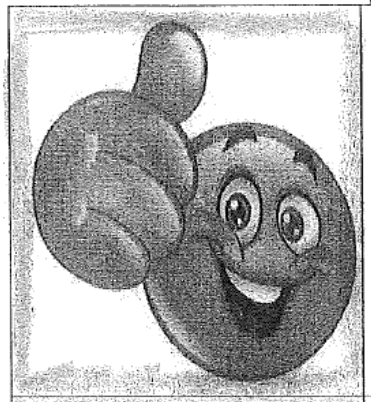
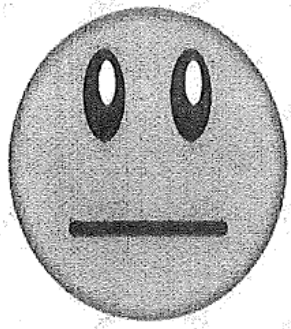
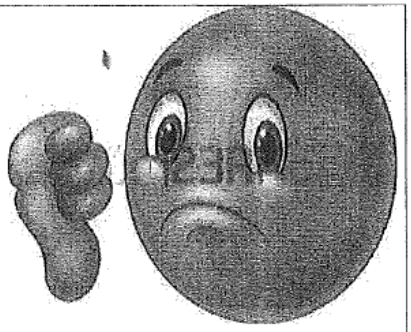
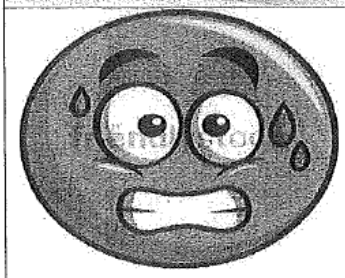
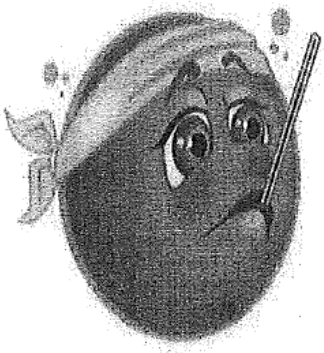
SESSION 5:

ROLLING WITH ROLE MODELS



SESSION 5 CHECK IN:

DATE: 30 August 2018

		
GOOD	**OKAY**	**BAD**
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

Today I wrote my maths test and I did very good.

REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

When our fascilitator gave us stories to read about the models.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

Half of the group was not here.

WHAT DID I DISCOVER ABOUT MYSELF?

I can get qualities about someone else from a model.

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

None.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

None

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They told me that I can be a great lawyer and I am good at poems and stories

HOW DID I HELP OTHERS DURING THIS SESSION?

I told them how good they are at things and showed them their qualities.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

When I was brave and showed everyone what they can actually normally I am just quiet and say it to myself.

IS THERE ANYTHING I CAN IMPROVE ON?

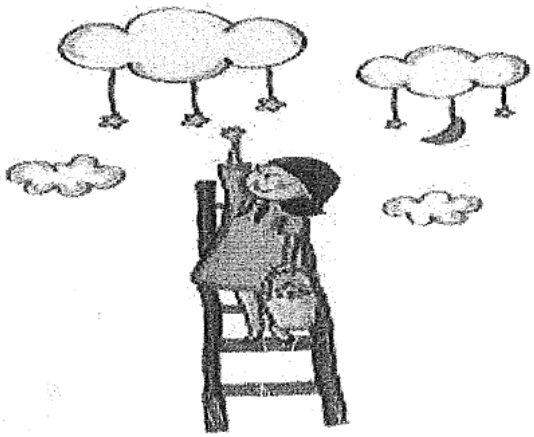
Being brave.

HOW AM I FEELING NOW?

Better than before all thanks to my group members.

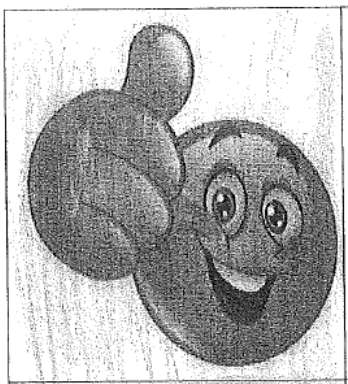
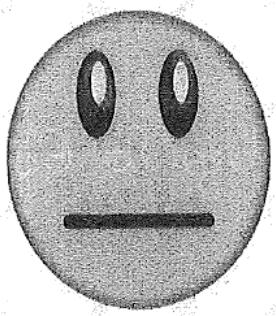
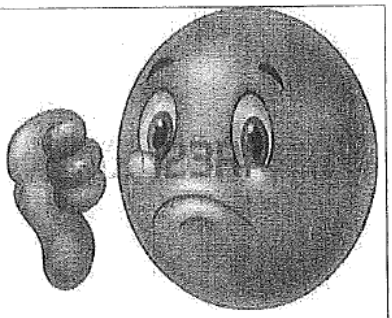
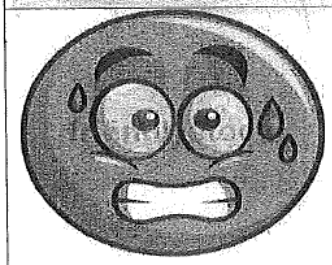
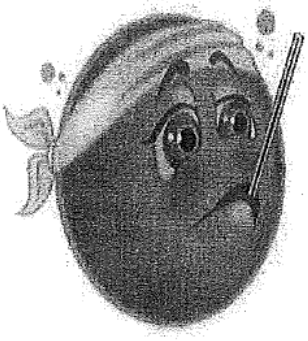
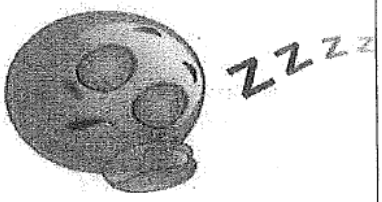
SESSION 6:

PERSONAL PROGRESS PATTERNS



SESSION 6 CHECK IN:

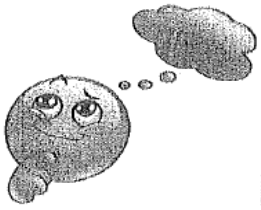
DATE: 14 September 2018

		
GOOD	**OKAY**	**BAD**
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

I am feeling this way because I was not rejected and I was accapted by a wonderful person



REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

When I made up our own choreography.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

No.

WHAT DID I DISCOVER ABOUT MYSELF?

That I can ~~betrr~~ if I believe in myself

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

The song picking.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

No.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

When I danced they did not judge.

HOW DID I HELP OTHERS DURING THIS SESSION?

I enjoyed everybodies choreography.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

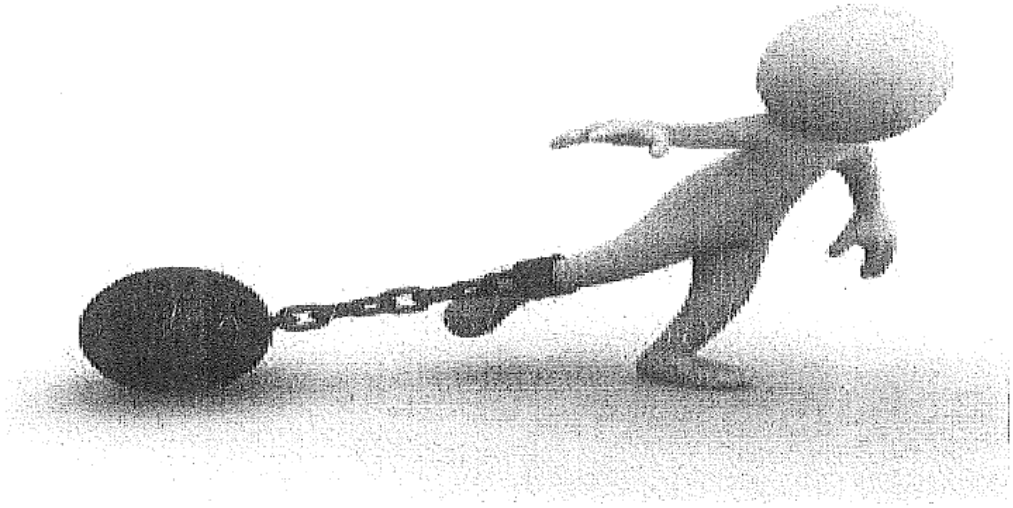
Dancing to my favourite song.

IS THERE ANYTHING I CAN IMPROVE ON?

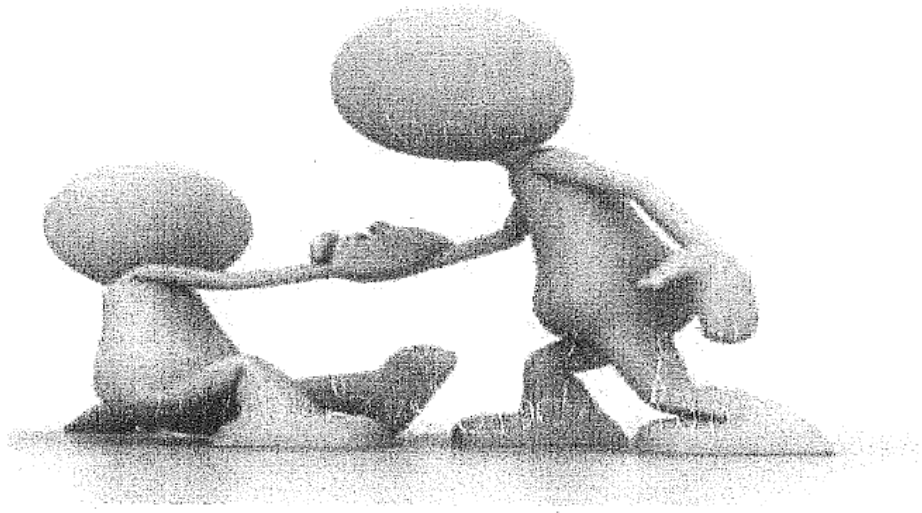
Being brave and more open.

HOW AM I FEELING NOW?

Better than before.

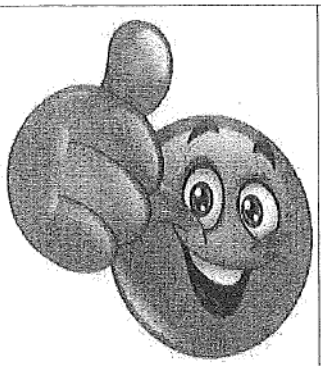
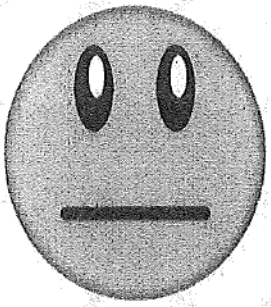
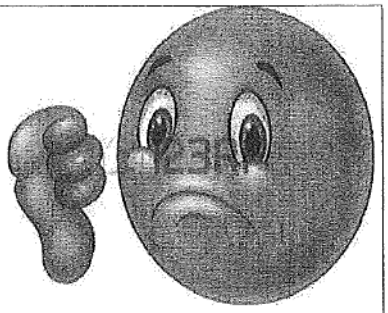
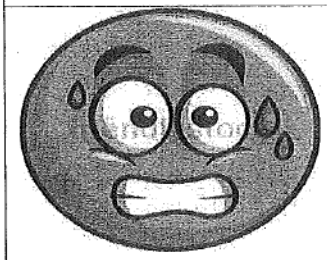
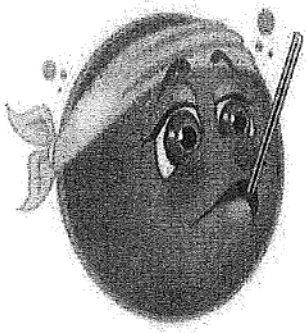


SESSION 7:
HOLDING BACK OR HELPING



SESSION 7 CHECK IN:

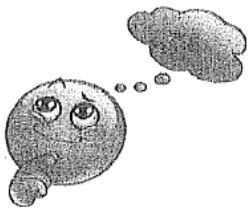
DATE: 6 September 2018

		
GOOD	**OKAY** ✓	**BAD**
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

I am feeling this way because today someone was telling me mean things and I tried to ignore it worked but I could not help it.



REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

~~I feel the same way.~~ There was nothing positive about it.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

There was nothing negative.

WHAT DID I DISCOVER ABOUT MYSELF?

Nothing.

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

When we had to be movers the first time, it was very hard to move.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

This session has shown me that I should let people give me freedom instead of doing things for us.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They showed me the difference ~~when~~ of being free and people doing things for me.

HOW DID I HELP OTHERS DURING THIS SESSION?

I helped them

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

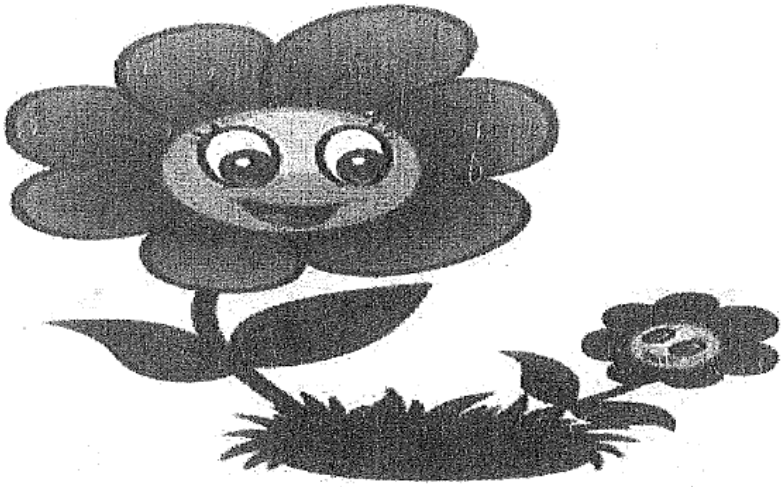
Nothing.

IS THERE ANYTHING I CAN IMPROVE ON?

There is nothing

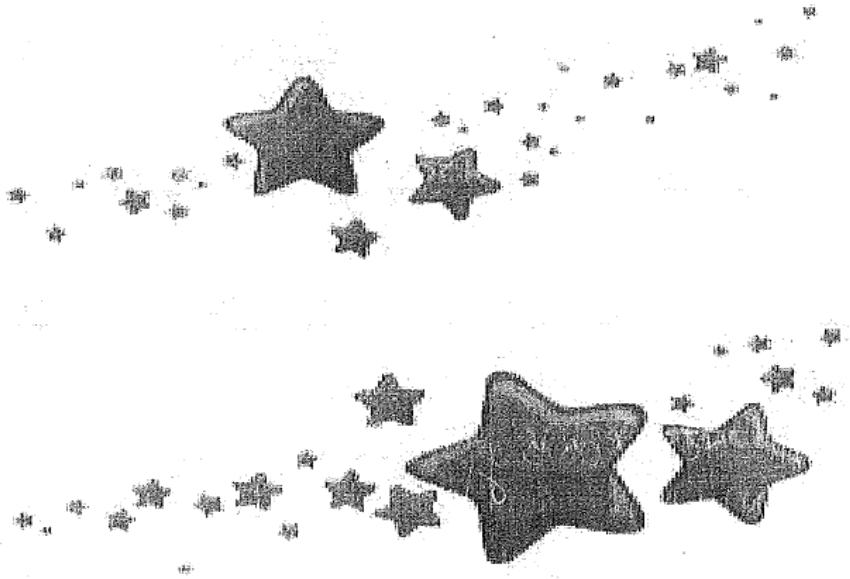
HOW AM I FEELING NOW?

I still feel okay but a bit better.



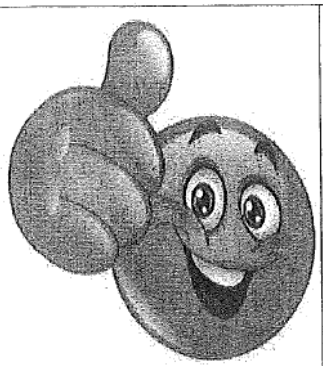
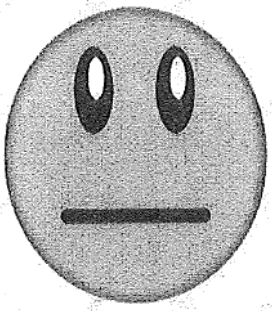
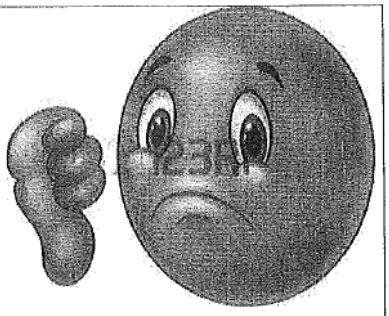
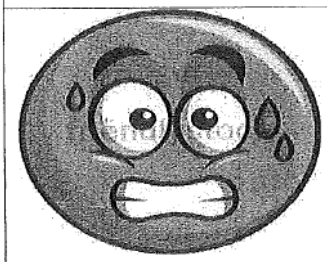
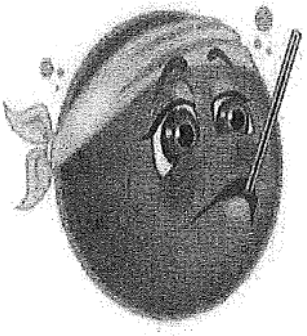
SESSION 8:

FROM SMALL TO TALL



SESSION 8 CHECK IN:

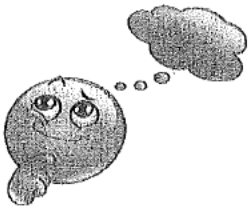
DATE: 11 September 2018

		
GOOD	**OKAY**	**BAD** ✓
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

We wrote two tests and today was someone specials birthday and I ~~did~~ bought a chocolate and their favourite body spray but that person did not come.



REFLECTION:

NOW THAT THE SESSION IS OVER, WHAT DO I THINK WAS POSITIVE ABOUT IT?

We had a great time, pasting and cutting.

WAS THERE ANYTHING NEGATIVE ABOUT THE SESSION?

Nothing ~~No~~ Some of the group members ~~did~~ could not make it.

WHAT DID I DISCOVER ABOUT MYSELF?

Nothing

WHAT WERE THE MOST CHALLENGING MOMENTS OF THE SESSION?

Being open.

ARE THERE ANY THOUGHTS OR FEELINGS THAT ARE KEEPING ME FROM FEELING BETTER ABOUT MYSELF?

There is nothing.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They did not judge.

HOW DID I HELP OTHERS DURING THIS SESSION?

When there were a few minutes I helped Portia finish pasting and spelt a word for her.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

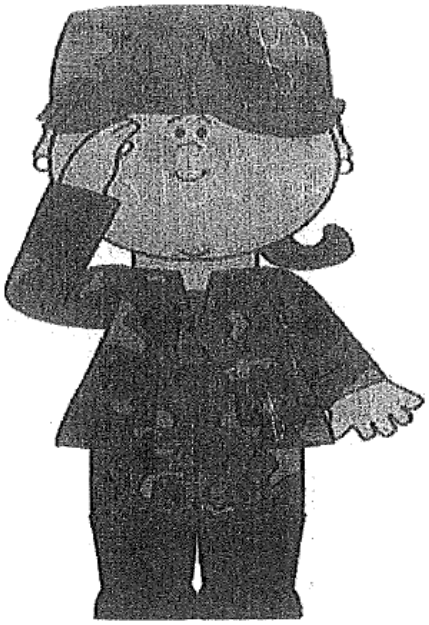
I ~~ha~~was open.

IS THERE ANYTHING I CAN IMPROVE ON?

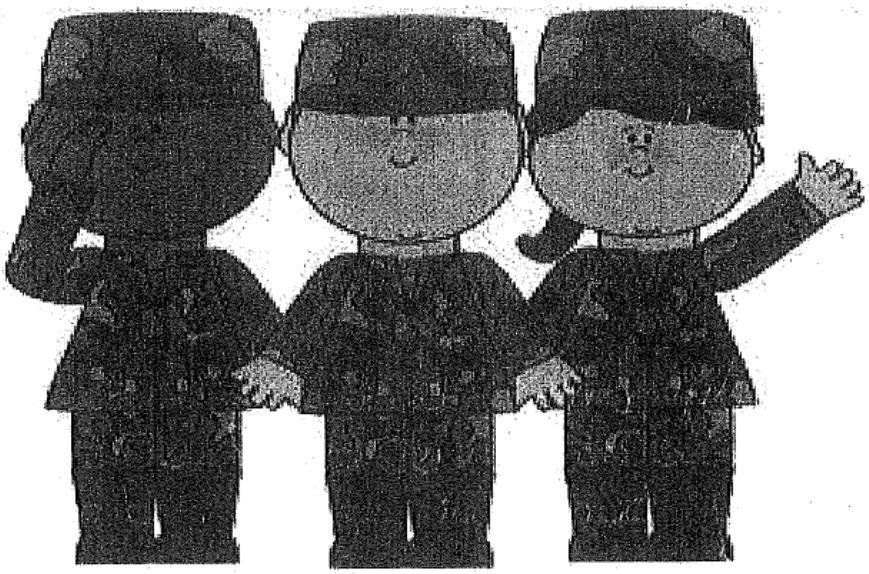
Being open.

HOW AM I FEELING NOW?

Not any different.



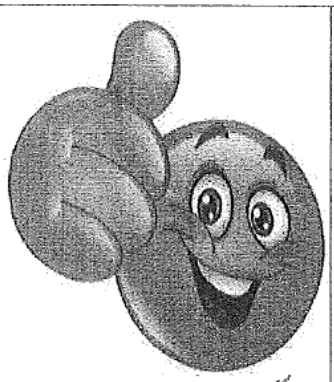
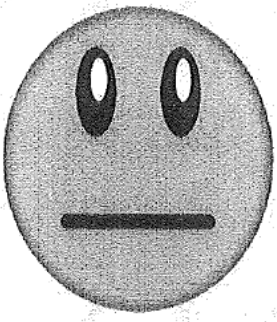
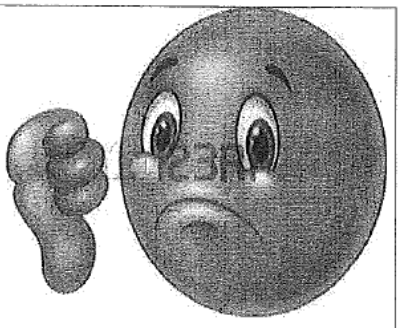
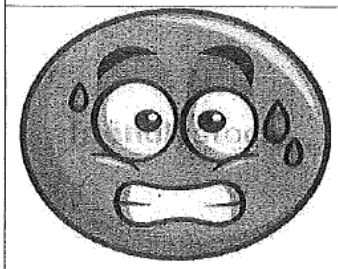
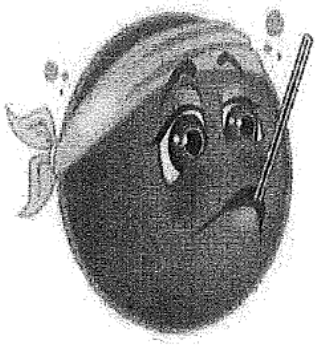
SESSION 9: SALUTE TO SELF-WORTH



SESSION 9 CHECK IN:

13 September 2018

DATE: ~~27 September 2018~~.

		
GOOD ✓	**OKAY**	**BAD**
		
NERVOUS	**SICK**	**TIRED**

OTHER:

WHY ARE YOU FEELING THIS WAY?

I felt very positive when I was writing my tests.

None.

WHAT DID MY GROUP MEMBERS DO TO SUPPORT OR ENCOURAGE ME?

They did not judge my moves.

HOW DID I HELP OTHERS DURING THIS SESSION?

I ~~d~~ joined them when they ~~AA~~ were doing moves.

WHAT WERE MY BIGGEST STRENGTHS DURING THIS SESSION?

When I showed everyone my moves without being shy.

IS THERE ANYTHING I CAN IMPROVE ON?

Being brave.

HOW AM I FEELING NOW?

Better than before. I feel excited.

Addendum M: Confidentiality agreement for professionals involved in the sample selection process

CONFIDENTIALITY AGREEMENT PERTAINING TO SAMPLING SELECTION

PROFESSIONAL CAPACITY:

_____

PLEDGE OF CONFIDENTIALITY

This is to certify that I, _____,
assisted in the sampling selection process for the research study titled "*Dance/Movement Therapy and the Psychosocial Well-Being of Learners with Visual Impairment: A Case Study*" by identifying prospective participants who according to my knowledge have low self-esteem.
I undertake to not divulge this information to anyone else other than the researcher of this particular study so as to safeguard and respect the anonymity and confidentiality of prospective participants.

_____ _____

Signature Date

_____ _____

Signature of researcher as witness Date

Addendum N: Confidentiality agreement for participants

CONFIDENTIALITY AGREEMENT

(Insert Group Name)

PLEDGE OF CONFIDENTIALITY

This is to certify that I,

_____,

a participant in this Dance/Movement Therapy Programme understand that any information (written, verbal or other form) obtained during the Dance/Movement Therapy sessions must remain confidential and must not be shared with anyone outside of this group.

This includes all information about myself, my fellow group members and our facilitator or any other information which I, my fellow group members or our facilitator might share through words, movements or in the DMT Journey Journals.

I understand that sharing this information outside of the Dance/Movement Therapy group can affect the feeling of trust between myself and my fellow group members and may be hurtful to one, more or all of them.

I thereby pledge to safeguard the trust my fellow group members have handed to me with the utmost care.

_____	_____
Signature	**Date**
_____	_____
Signature of researcher as witness	**Date**

Addendum O: Pre-intervention RSES of each participant
Addendum O (1): Pre-intervention RSES of Participant A

PARTICIPANT A
PRE-INTERVENTION

TOTAL 14
∴ LOW LEVEL OF SE

THE ROSENBERG SELF-ESTEEM SCALE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

(2) Strongly Agree Agree (Disagree) Strongly Disagree

(2) 2. At times I think I am no good at all.

Strongly Agree (Agree) Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

(1) Strongly Agree Agree Disagree (Strongly Disagree)

4. I am able to do things as well as most other people.

(1) Strongly Agree Agree Disagree (Strongly Disagree)

5. I feel I do not have much to be proud of.

(2) Strongly Agree (Agree) Disagree Strongly Disagree

6. I certainly feel useless at times.

(2) Strongly Agree (Agree) Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

(1) Strongly Agree Agree Disagree (Strongly Disagree)

8. I wish I could have more respect for myself.

(1) (Strongly Agree) Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

(1) (Strongly Agree) Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

(1) Strongly Agree Agree Disagree (Strongly Disagree)

Addendum O (2): Pre-intervention RSES of Participant B

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT B PRE-INTERVENTION TOTAL: 13 ∴ LOW LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

① Strongly Agree Agree Disagree ~~Strongly Disagree~~

2. At times I think I am no good at all.

① ~~Strongly Agree~~ Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

① Strongly Agree Agree Disagree ~~Strongly Disagree~~

4. I am able to do things as well as most other people.

① Strongly Agree Agree Disagree ~~Strongly Disagree~~

5. I feel I do not have much to be proud of.

① ~~Strongly Agree~~ Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

① ~~Strongly Agree~~ Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

① Strongly Agree Agree ~~Disagree~~ Strongly Disagree

8. I wish I could have more respect for myself.

① Strongly Agree ~~Agree~~ Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

① Strongly Agree ~~Agree~~ Disagree Strongly Disagree

10. I take a positive attitude toward myself.

① Strongly Agree Agree Disagree ~~Strongly Disagree~~

Addendum O (3): Pre-intervention RSES of Participant C

THE ROSENBERG SELF-ESTEEM SCALE

PARTICIPANT C
PRE-INTERVENTION

TOTAL: 15
∴ NORMAL LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

① Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

② Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

① Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

① Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

① Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

② Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

② Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

② Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

① Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

② Strongly Agree Agree Disagree Strongly Disagree

Addendum O (4): Pre-intervention RSES of Participant D

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT D: PRE-INTERVENTION TOTAL: 10 ∴ LOW LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

① Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

① Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

① Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

① Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

① Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

① Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

① Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

① Strongly Agree Agree Disagree Strongly Disagree

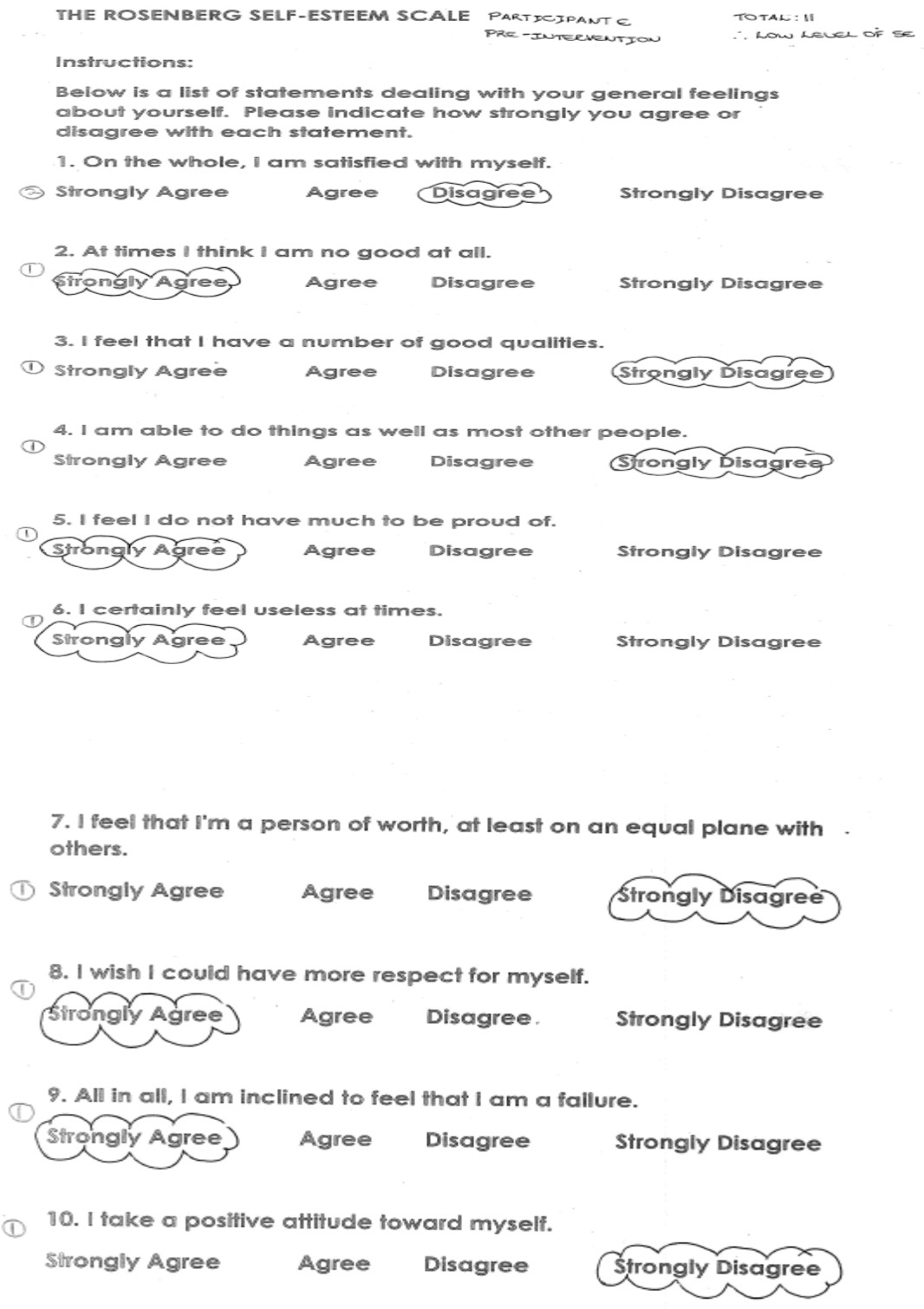
9. All in all, I am inclined to feel that I am a failure.

① Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

① Strongly Agree Agree Disagree Strongly Disagree

Addendum O (5): Pre-intervention RSES of Participant E



THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT E PRE-INTERVENTION TOTAL: 11 ∴ LOW LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

2 Strongly Agree Agree (Disagree) Strongly Disagree

2. At times I think I am no good at all.

1 (Strongly Agree) Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

1 Strongly Agree Agree Disagree (Strongly Disagree)

4. I am able to do things as well as most other people.

1 Strongly Agree Agree Disagree (Strongly Disagree)

5. I feel I do not have much to be proud of.

1 (Strongly Agree) Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

1 (Strongly Agree) Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

1 Strongly Agree Agree Disagree (Strongly Disagree)

8. I wish I could have more respect for myself.

1 (Strongly Agree) Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

1 (Strongly Agree) Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

1 Strongly Agree Agree Disagree (Strongly Disagree)

Addendum O (6): Pre-intervention RSES of Participant F

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT F PRE-INTERVENTION TOTAL: 10 ∴ LOW LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

2. At times I think I am no good at all.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

4. I am able to do things as well as most other people.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

5. I feel I do not have much to be proud of.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

8. I wish I could have more respect for myself.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

Addendum P: Post-intervention RSES of each participant
Addendum P (1): Post-intervention RSES of Participant A

THE ROSENBERG SELF-ESTEEM SCALE

PARTICIPANT A
POST - INTERVENTION

TOTAL: 18
∴ NORMAL LEVEL OF SC

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

③ Strongly Agree (Agree) Disagree Strongly Disagree

2. At times I think I am no good at all.

② Strongly Agree (Agree) Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

② Strongly Agree Agree (Disagree) Strongly Disagree

4. I am able to do things as well as most other people.

② Strongly Agree Agree (Disagree) Strongly Disagree

5. I feel I do not have much to be proud of.

③ Strongly Agree Agree (Disagree) Strongly Disagree

6. I certainly feel useless at times.

② Strongly Agree (Agree) Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

① Strongly Agree Agree Disagree (Strongly Disagree)

8. I wish I could have more respect for myself.

① (Strongly Agree) Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

① (Strongly Agree) Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

① Strongly Agree Agree Disagree (Strongly Disagree)

Addendum P (2): Post-intervention RSES of Participant B

PARTICIPANT B
POST-INTERVENTION

TOTAL: 16
∴ NORMAL LEVEL OF SE.

THE ROSENBERG SELF-ESTEEM SCALE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

(2) Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

(1) Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

(3) Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

(1) Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

(1) Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

(1) Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

(2) Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

(1) Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

(3) Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

(2) Strongly Agree Agree Disagree Strongly Disagree

Addendum P (3): Post-intervention RSES of Participant C

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT C POST-INTERVENTION TOTAL: 16 ∴ NORMAL LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

(2) Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

(1) Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

(1) Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

(1) Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

(2) Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

(2) Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

(2) Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

(2) Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

(2) Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

(1) Strongly Agree Agree Disagree Strongly Disagree

Addendum P (4): Post-intervention RSES of Participant D

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT D POST-INTERVENTION TOTAL: 19 ∴ NORMAL LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

(3) Strongly Agree **Agree** Disagree Strongly Disagree

2. At times I think I am no good at all.

(2) Strongly Agree **Agree** Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

(3) Strongly Agree **Agree** Disagree Strongly Disagree

4. I am able to do things as well as most other people.

(2) Strongly Agree Agree **Disagree** Strongly Disagree

5. I feel I do not have much to be proud of.

(2) Strongly Agree **Agree** Disagree Strongly Disagree

6. I certainly feel useless at times.

(1) **Strongly Agree** Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

(2) Strongly Agree Agree **Disagree** Strongly Disagree

8. I wish I could have more respect for myself.

(1) **Strongly Agree** Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

(2) Strongly Agree **Agree** Disagree Strongly Disagree

10. I take a positive attitude toward myself.

(1) Strongly Agree Agree Disagree **Strongly Disagree**

Addendum P (5): Post-intervention RSES of Participant E

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT E POST-INTERVENTION TOTAL: 14 ∴ LOW LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

① Strongly Agree Agree Disagree ✳Strongly Disagree

2. At times I think I am no good at all.

① ✳Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

② Strongly Agree Agree ✳Disagree Strongly Disagree

4. I am able to do things as well as most other people.

① Strongly Agree Agree Disagree ✳Strongly Disagree

5. I feel I do not have much to be proud of.

② Strongly Agree ✳Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

② Strongly Agree ✳Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

② Strongly Agree Agree ✳Disagree Strongly Disagree

8. I wish I could have more respect for myself.

① ✳Strongly Agree Agree Disagree Strongly Disagree

✳Sorry Mam

9. All in all, I am inclined to feel that I am a failure.

① ✳Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

① Sorry Mam ✳Strongly Agree Agree Disagree ✳Strongly Disagree

Addendum P (6): Post-intervention RSES of Participant F

THE ROSENBERG SELF-ESTEEM SCALE PARTICIPANT F
POST-INTERVENTION

TOTAL: 13
∴ LOW LEVEL OF SE

Instructions:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

2. At times I think I am no good at all.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

(2) Strongly Agree Agree Disagree ✓ Strongly Disagree

4. I am able to do things as well as most other people.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

5. I feel I do not have much to be proud of.

(2) Strongly Agree Agree ✓ Disagree Strongly Disagree

6. I certainly feel useless at times.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

8. I wish I could have more respect for myself.

(2) Strongly Agree Agree ✓ Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

(1) Strongly Agree ✓ Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

(1) Strongly Agree Agree Disagree Strongly Disagree ✓

Addendum Q: Compiled Code of Conduct

STARLIGHT MIX CODE OF CONDUCT

1. WE MAY NOT JUDGE EACH OTHER
2. WE MUST ALWAYS ACT AND SPEAK WITH LOVE AND KINDNESS
3. WE MUST BUILD EACH OTHER UP; NOT BREAK EACH OTHER DOWN
4. BE ON TIME
5. WE MAY NOT LAUGH AT EACH OTHER – WE ONLY LAUGH TOGETHER
6. WE MUST RESPECT EACH OTHER DURING AND ALSO AFTER EACH SESSION
7. WHAT IS SAID OR EXPRESSED IN THE GROUP STAYS IN THE GROUP
8. ALWAYS BE YOURSELF
9. WE WILL NOT ACT LIKE WE ARE BETTER THAN ANY ONE ELSE IN THE GROUP
10. WE WILL RESPECT OUR FASCILITATOR
11. WE WILL NOT DISCUSS EACH OTHER WITH ONE ANOTHER OR WITH ANY ONE ELSE OUTSIDE THE GROUP
12. WE WILL DRESS APPROPRIATELY
13. WE MUST BELIEVE IN OURSELVES
14. ITS OKAY TO FEEL
15. WE WILL ALWAYS ADDRESS EACH OTHER WITH RESPECT
16. DON'T BE A BULLY
17. LOVE YOURSELF AND EACH OTHER

_____ _____

NAME SIGNATURE

_____

DATE

Addendum R: Observation schedules of each participant
Addendum R (1): Observation schedules of Participant A

OBSERVATION SCHEDULE

Session: 2 **Theme: Create Connection and Cohesion** **Participant: A**

Shape	Rising or **sinking**	Spreading or **enclosing**	Advancing or **retreating**	Growing or **shrinking**	Lengthening or **shortening**	Widening or **narrowing**
Effort	Flow of movement: free	Flow of movement: **bound**	Weight: Light and **limp**	Weight: Strong and heavy	Time: Sustained	Time: **Sudden and quick**
Space	Increased use of space			**Decreased use of space**		
Movement	**Body-half** **Upper body**	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Rocking side ways o Hugging self o Shape of heart with hands					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: o Looks down o Giggles a lot (especially when looking in the mirror)					
Other observations	o Blushes when corrected during warm up exercise o Movements very unsure o Willing to go first to encourage others to follow o "I want to love myself the way others love me" o High fives every participant who goes after her					

OBSERVATION SCHEDULE

Session: 3 **Theme: Words Shape Me** **Participant: A**

Shape * Very limited(arms above head& small jump)	***Rising** or sinking	***Spreading** or enclosing	Advancing or retreating	***Growing** or shrinking	***Lengthening** or shortening	Widening or **narrowing**
Effort	Flow of movement: free	Flow of movement: **bound**	Weight: **Light** and limp	Weight: Strong and heavy	Time: Sustained	Time: **Sudden and quick**
Space	Increased use of space			**Decreased use of space**		
Movement * Very limited (arms above head and small jump)	**Body-half** **Upper body**	***Vertical**	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Forming heart with hands o Swaying from side to side					
Any movement preferences	If yes, describe: Hand and arm movements					
Facial expressions	Describe: o Still looks down a lot o Still very giggly					
Other observations	o Warm-up movements very uncertain and small o Self soothing movements like hugging self and swinging back and forth o Hands behind back o Looks around at others for affirmation o Improvised movement: slight increase in range of movement but still small and close to body o Structured movement: slightly stronger but still limited in range of movement o Freestyle: Free, wants to experiment with movement					

OBSERVATION SCHEDULE

Session: 4 **Theme: Feeling feelings** **Participant: A**

Shape * Slight arm movements above head and to the sides	***Rising** or sinking	***Spreading** or enclosing	**Advancing** or retreating	***Growing** or shrinking	***Lengthening** or shortening	***Widening** or narrowing
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: **Light** and limp	Weight: Strong and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space**(Use of arms and moving forward)			Decreased use of space		
Movement * Limited to arm movements	Body-half	***Vertical**	***Horizontal**	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Hugging self					
Any movement preferences	If yes, describe: o Arm movements					
Facial expressions	Describe: o Smiling					
Other observations	o Movements stronger and bigger during warm up o Tries to include peer who feels left out o Eager to try movement o Movement uses more space (turns) o Improvised movement: isolated head movements; Arms close to body o Structured movement:Wider, open arms o Linking movement: stronger, bigger movements slightly lifted above head, push (but not fully extend)					

OBSERVATION SCHEDULE

Session: 5 **Theme: Rolling with role models** **Participant: A**

Shape * Improvised movement ** Structured movement	Rising or sinking	Spreading or **enclosing**	Advancing or retreating	Growing or shrinking	**Lengthening or shortening	**Widening or narrowing
Effort * Improvised movement ** Structured movement	Flow of movement: **free**	Flow of movement: *bound	Weight: *Light and limp	Weight: **Strong and heavy	Time: Sustained	Time: **Sudden and quick**
Space	**Increased use of space**			Decreased use of space		
Movement * Improvised movement ** Structured movement	*Body-half Upper body	Vertical	**Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Turns ○ Spreading out arms to the side					
Any movement preferences	If yes, describe: ○ Turns ○ Arm movements					
Facial expressions	Describe: ○ Smiling					
Other observations	○ More controlled movements ○ Improvised movement: Uncertain to share movement with others (switches from one leg to the other); Small movements close to body ○ Structured movement: Use space by turning and spreading arms, More confident					

OBSERVATION SCHEDULE

Session: 6 **Theme: Personal progress patterns** **Participant: A**

Shape	Rising or sinking	**Spreading** or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	**Widening** or narrowing
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: Light and limp	Weight: **Strong** and heavy	Time: Sustained	Time: **Sudden and quick**
Space	**Increased use of space**			Decreased use of space		
Movement	Body-half	Vertical	**Horizontal**	**Cross-lateral**	Sagittal	Core support
Any recurring patterns	If yes, describe: o Spreading arms to the side o Turning					
Any movement preferences	If yes, describe: o Arm movements o Turns					
Facial expressions	Describe: o Smiling					
Other observations	o More controlled movements; o Confident; Wants to go first o Movements are stronger and more defined o Use horizontal space o Adds rhythm					

OBSERVATION SCHEDULE

Session: 7 **Theme: Holding back or helping** **Participant: A**

Shape *Structured movement (lifted and extended movement)	*Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	*Lengthening or shortening	Widening or narrowing
Effort *Improvised movement ** Structured movement	Flow of movement: **free	Flow of movement: *bound	Weight: **Light and limp	Weight: **Strong and *heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(moving forwards and backwards)			Decreased use of space		
Movement * Improvised movement	*Body-half Lower body	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Walking forwards and backwards					
Any movement preferences	If yes, describe: o Leg movements (which is not usually her preferred movement = being held back from doing what she wants to do. When supported in structured movement sequence, she reverts back to arm movements)					
Facial expressions	Describe: o Frown during improvised movement o Smile during structured movement					
Other observations	o Bigger, stronger more definite o Less looking around at others o Improvised movement: Restricted; Limited range of movement; No use of arms (which is usually her preferred movement) o Structured movement: More movement in space; Can use arms and mentions that she can keep arms in air for longer; States that she feels safe to try new movements o Free movement to music depicts more elaborate and extended movements					

OBSERVATION SCHEDULE

Session: 8 **Theme: From small to tall** **Participant: A**

Shape	**Rising and sinking**	**Spreading and enclosing**	**Advancing and retreating**	**Growing and shrinking**	**Lengthening** or shortening	**Widening** or narrowing
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: **Light** and limp	Weight: **Strong** and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space**			Decreased use of space		
Movement	Body-half	**Vertical**	**Horizontal**	**Cross-lateral**	**Sagittal**	Core support
Any recurring patterns	If **yes**, describe: o Holding and releasing o Contracting and expanding					
Any movement preferences	If **yes**, describe: o Arm movements o Turns					
Facial expressions	Describe: Very emotional; Feeling of each movement (hurt; fear; joy; relief) was etched on her face					
Other observations	o Jumps up and down and claps hands together when achieve success o Improvised movement: More control; Extended movement; More independent; Still use small horizontal space, but increase in vertical movement o Structured movement: Down and up; Leap forward; Turn across floor diagonally; Contract and expand; Use space vertically and horizontally; Strong and confident mover o Very expressive; Emotional movement piece					

OBSERVATION SCHEDULE

Session: 9 **Theme: Salute to self-worth** **Participant: A**

Shape	Rising or sinking	**Spreading** or enclosing	**Advancing** or retreating	Growing or shrinking	**Lengthening** or shortening	**Widening** or narrowing
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: Light and limp	Weight: **Strong** and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space** (Forwards and sideways)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	**Cross-lateral**	**Sagittal**	Core support
Any recurring patterns	If yes, describe: ○ Walkingforward					
Any movement preferences	If yes, describe: ○ Leg and arm movements					
Facial expressions	Describe: ○ Pleading but smiling					
Other observations	○ Improvised movement: Independent movement; Strong, focused and defined (stomps with extended arms and hands in fists); Moving forward with determination; Expressive face ○ Structured movement: Confident and deliberate movement as a whole, but still looks at others from time to time; Pure enjoyment on her face ○ Freestyle movement: Very spontaneous; Almost childlike; Completely vulnerable					

Addendum R (2): Observation schedules of Participant B

OBSERVATION SCHEDULE

Session: 2 **Theme: Create Connection and Cohesion** **Participant: B**

Shape * On toes as a nervous action	*Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half Upper body	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Hand movements Stand on toes (demi-point)					
Any movement preferences	If yes, describe: Arms stay close to body					
Facial expressions	Describe: o Hand in front of mouth o Hides face behind mirror o Looks down a lot or looks at Participant C o Hands behind back or on hips o Shows a thumbs down sign after completing her movement sequence					
Other observations	o Hesitant to show movement sequence to others o Stays close to or in the group at all times o "I am closed up now, but I want to open up"					

OBSERVATION SCHEDULE

Session: 3 **Theme: Words Shape Me** **Participant: B**

Shape * Arm movements	**Rising** or sinking	Spreading or ***enclosing**	**Advancing** or retreating	**Growing** or shrinking	Lengthening or ***shortening**	Widening or ***narrowing**
Effort	Flow of movement: free	Flow of movement: **bound**	Weight: Light and **limp**	Weight: Strong and heavy	Time: Sustained	Time: **Sudden and quick**
Space * Back and forward	***Increased use of space**			Decreased use of space		
Movement	**Body-half**	Vertical	**Horizontal** (Backwards and forwards)	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Swinging arms					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: ○ Hides face behind hands ○ Bites lip					
Other observations	○ Looks to others for affirmation ○ Improvised movement sequence: small, fast, uncertain movements ○ Structured movement: more open, wider movements executed with a bit more confidence, but still light and limp ○ Very uncertain with freestyle movement; does not really move; just looks around					

OBSERVATION SCHEDULE

Session: 4 **Theme: Feeling feelings** **Participant: B**

Shape * Improvised movement ** Structured movement	Rising or *sinking	Spreading or *enclosing	Advancing or *retreating	**Growing or shrinking	**Lengthening or shortening	**Widening or narrowing
Effort * Progressive execution	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: *Sustained	Time: Sudden and quick
Space	Increased use of space(Up and down as well as conceptually as she mentions turns but does not execute them yet)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Spreading arms					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: ○ Bites lip					
Other observations	○ Warm up moves bigger and stronger ○ More independent movement ○ Improvised movement:Close to body and ground ○ Structured movement: Wider, open arms, gets up onto bench, use space vertically ○ Linking movement: Wants to turn but does not execute, only describes(possibly does not feel ready yet)					

OBSERVATION SCHEDULE

Session: 5 **Theme: Rolling with role models** **Participant: B**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 6 **Theme: Personal progress patterns** **Participant: B**

Shape	Rising or sinking	**Spreading** or enclosing	Advancing or retreating	Growing or shrinking	**Lengthening** or shortening	**Widening** or narrowing
Effort * Improvised movement ** Structured movement	Flow of movement: **free**	Flow of movement: bound	Weight: ****Light** and limp	Weight: ***Strong** and heavy	Time: Sustained	Time: **Sudden and quick**
Space	**Increased use of space**			Decreased use of space		
Movement	Body-half	Vertical	**Horizontal**	**Cross-lateral**	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Spreading arms side ways					
Any movement preferences	If yes, describe: ○ Arm movements					
Facial expressions	Describe: ○ Smiling ○ Bite lip					
Other observations	○ Hands in front of body, folded for majority of the session ○ Improvised movement: Bigger and stronger arm movements; Move horizontally in space ○ Structured movement: Small, softer arm movements but still use horizontal space					

OBSERVATION SCHEDULE

Session: 7 **Theme: Holding back or helping** **Participant: B**

Shape * Improvised movement ** Structured movement	**Rising or sinking	**Spreading or enclosing	Advancing or retreating	Growing or *shrinking	**Lengthening or shortening	Widening or *narrowing
Effort * Improvised movement ** Structured movement	Flow of movement: **free	Flow of movement: *bound	Weight: **Light and limp	Weight: Strong and *heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Forwards and backwards; Up and down)			Decreased use of space		
Movement * Improvised movement	*Body-half Lower body	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Rising ○ Turning					
Any movement preferences	If yes, describe: ○ Rising and turning (Movements that allow to break free from other participants' restraints. Usual preferred arm movements return during structured movements sequence where movement is supported and not restricted = During improvised movement she felt held back from what she really wanted to do)					
Facial expressions	Describe: ○ Frustrated expression during improvised movement ○ Smiling, more relaxed facial expression during structured movement sequence					
Other observations	○ Improvised movement: Restricted, Limited range of movement, Can't use space horizontally, so try to release through vertical movement which leads to narrowing of movement and as she is being pulled down, her movements seem heavy – which are all the opposite descriptions of her usual movements ○ Structured movement: Lighter; Supported; More daring; Turn faster with momentum gathered from support; Uses arms movements which are elongated with support (where arm movements are usually limp)					

OBSERVATION SCHEDULE

Session: 8 **Theme: From small to tall** **Participant: B**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement:f ree	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 9 **Theme: Salute to self-worth** **Participant: B**

Shape	Rising or sinking	**Spreading and enclosing**	Advancing or retreating	Growing or shrinking	**Lengthening** or shortening	**Widening and narrowing**
Effort * Improvised movement ** Structured movement	Flow of movement: **free**	Flow of movement: bound	Weight: **Light** and ***limp**	Weight: ****Strong** and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space**(Move on a horizontal plane, but very slight and always returns close to body)			Decreased use of space		
Movement	Body-half	Vertical	**Horizontal**	**Cross-lateral**	**Sagittal**	Core support
Any recurring patterns	If **yes**, describe: ○ Contracting and expanding					
Any movement preferences	If **yes**, describe: ○ Hand and arm movements					
Facial expressions	Describe: ○ Determined and smiles at the end					
Other observations	○ Improvised movement: Independent and original movement; Open, definite and expressive, but still close to the body and limited use of horizontal space ○ Structured movement: Still a bit floppy at the start of the sequence, but becomes stronger as she gains confidence in her movements ○ Freestyle movement: A bit unsure but as group gets started, movement becomes more spontaneous; The moment she feels like someone is watching her though, she becomes self-conscious again and her movements decrease in size and the space they take up					

Addendum R (3): Observation schedules of Participant C

OBSERVATION SCHEDULE

Session: 2 **Theme: Create Connection and Cohesion** **Participant: C**

Shape * As session progresses	Rising or **sinking**	***Spreading** or enclosing	***Advancing** or retreating	Growing or **shrinking**	Lengthening or **shortening**	***Widening** or narrowing
Effort	Flow of movement: free	Flow of movement: **bound**	Weight: Light and limp	Weight: **Strong** and heavy	Time: Sustained	Time: **Sudden and quick**
Space * As session progresses	***Increased use of space**			Decreased use of space		
Movement * As session progresses	Body-half	Vertical	***Horizontal**	***Cross-lateral**	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe: Arm and hip movements					
Facial expressions	Describe: ○ Looks down or at Participant B a lot					
Other observations	○ Hands behind back or on hips ○ Walks back and forth when handed the mirror and before looking into it ○ Giggles with hand in front of mouth when looking in the mirror ○ Shrugs before showing her movement sequence ○ Very hesitant to start with movement sequence ○ Looks at others for help and encouragement ○ Hides face in hands and crouches down ○ "I am excited to move and to open up to loving myself"					

OBSERVATION SCHEDULE

Session: 3 **Theme: Words Shape Me** **Participant: C**

Shape	Rising or **sinking**	**Spreading** or enclosing	Advancing or retreating	Growing or **shrinking**	Lengthening or **shortening**	**Widening** or narrowing
Effort *still limited but more so in comparison with other participants	Flow of movement: ***free**	Flow of movement: bound	Weight: **Light** and limp	Weight: **Strong** and heavy	Time: Sustained	Time: **Sudden and quick**
Space	**Increased use of space**			Decreased use of space		
Movement	Body-half	Vertical	**Horizontal as well as backward and forwards**	**Cross-lateral**	Sagittal	Core support
Any recurring patterns	If yes, describe: Releasing movements					
Any movement preferences	If yes, describe: Arm and leg extensions					
Facial expressions	Describe: o Covers face with hands a lot o Looks down constantly o Giggles o Fidgets with clothes and hair					
Other observations	o Looks to facilitator for confirmation. o Wants to do everything perfectly o Self soothing movements like rocking back and forth o Improvised movement: Movements away from body; use levels; pulls and throws down o Structured movement: Hesitant to come forward; use levels and moves forward; strong and confident but gets angry when she makes a mistake and wants to do it over o Freestyle movement: free and flowing; starts with big elaborate movements and then becomes small when she realizes that others are watching her					

OBSERVATION SCHEDULE

Session: 4 **Theme: Feeling feelings** **Participant: C**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 5 **Theme: Rolling with role models** **Participant: C**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement:free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 6 **Theme: Personal progress patterns** **Participant: C**

Shape * Improvised movement	**Rising** or sinking	**Spreading** or enclosing	Advancing or retreating	Growing or ***shrinking**	**Lengthening** or shortening	**Widening** or narrowing
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: **Light** and limp	Weight: **Strong** and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space**			Decreased use of space		
Movement	Body-half	**Vertical**	**Horizontal**	**Cross-lateral**	**Sagittal**	Core support
Any recurring patterns	If **yes**, describe: ○ Contracting into a ball and then expanding (using levels)					
Any movement preferences	If **yes**, describe: ○ Arm and leg movements					
Facial expressions	Describe: ○ Smiling					
Other observations	○ Improvised movement: Strong, extended and confident movements using space horizontally and vertically ○ Structured movement: Elongated and sweeping arm movements using horizontal and vertical space and including cross-lateral and sagittal movements as well ○ Adds rhythm					

OBSERVATION SCHEDULE

Session: 7 **Theme: Holding back or helping** **Participant: C**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 8 **Theme: From small to tall** **Participant: C**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement:free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 9 **Theme: Salute to self-worth** **Participant: C**

Shape	**Rising** or sinking	**Spreading and enclosing**	**Advancing** or retreating	**Growing and shrinking**	**Lengthening and shortening**	**Widening and narrowing**
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: **Light** and limp	Weight: **Strong** and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space**(Sideways; Up and down; Forwards and backwards)			Decreased use of space		
Movement	Body-half	**Vertical**	**Horizontal**	**Cross-lateral**	**Sagittal**	Core support
Any recurring patterns	If yes, describe: ○ Contracting and expanding ○ Widening and narrowing ○ Lengthening and shortening					
Any movement preferences	If yes, describe: ○ Finger, hand and arm movements ○ Hip movements					
Facial expressions	Describe: ○ Determined and proud					
Other observations	○ Improvised movement: Calmer and more confident even when she makes a mistake, she just asks if she may start over; Uses every part of body even fingers;Creative and original use of space and levels; Very pertinent, definite and expressive movements; Convincing execution ○ Structured movement: Adds rhythm and personality as she becomes more acquainted with the sequence; Pure enjoyment on her face ○ Freestyle movement: Takes the lead; Psych up other participants; Very rhythmic; Enjoys spontaneous movement					

Addendum R (4): Observation schedules of Participant D

OBSERVATION SCHEDULE

Session: 2 **Theme: Create Connection and Cohesion** **Participant: D**

Shape * When not executing movement	Rising or *sinking	Spreading or enclosing	Advancing or *retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half Upper body	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Circling arms					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: Looks down a lot					
Other observations	○ Scared to do something wrong ○ Very surprised at own ability ○ Arms folded close to chest during most of the session ○ Runs away when handed the mirror ○ When taking the mirror, walks to someone else to look at it with her ○ "Everyone's love makes me love myself"					

OBSERVATION SCHEDULE

Session: 3 **Theme: Words Shape Me** **Participant: D**

Shape * Moving away slightly from body centre	Rising or sinking	*Spreading or enclosing	Advancing or retreating	Growing or shrinking	*Lengthening or shortening	*Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement * Very limited	Body-half Upper body	Vertical	*Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Blowing kisses Opening arms to the side					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: ○ Always smiling ○ Wrings hands ○ Fidgets					
Other observations	○ Keeps to herself for the majority of the session ○ Improvised movement: Small movements close to body; pushing away ○ Structured movement: Starts to move away from body, but still small and limited range of movement using only the upper body; movements are uncertain ○ Freestyle movement: keeps close to body centre, looks at others					

OBSERVATION SCHEDULE

Session: 4 **Theme: Feeling feelings** **Participant: D**

Shape * Improvised movement ** Structured movement	Rising or *sinking	Spreading or *enclosing	Advancing or *retreating	**Growing or shrinking	**Lengthening or shortening	**Widening or narrowing
Effort * Progressive execution	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: *Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Hugging self o Opening arms					
Any movement preferences	If yes, describe: o Arm movements o Turns					
Facial expressions	Describe: o Smiling					
Other observations	o Starts to move closer to the group o Uses more space o Improvised movement:Movements close to body, hugging, hunched posture, close to the ground o Structured movement: Arms wide open,using space horizontally o Linking movement: Bigger movements using space (turns)					

OBSERVATION SCHEDULE

Session: 5 **Theme: Rolling with role models** **Participant: D**

Shape * Improvised movement ** Structured movement	Rising or sinking	Spreading or *enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	**Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half Upper body	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Swaying from side to side					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: ○ Smiling					
Other observations	○ Feels more comfortable in smaller group ○ Improvised and structured movements: Movementssmall and close to body but stronger and more definite, exhuming more confidence					

OBSERVATION SCHEDULE

Session: 6 **Theme: Personal progress patterns** **Participant: D**

Shape * Structured movement	Rising or *sinking	*Spreading or enclosing	Advancing or retreating	Growing or *shrinking	Lengthening or shortening	*Widening or narrowing
Effort * Arm movements ** Rest of the body	Flow of movement: *free	Flow of movement: **bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space * Limited to arm movementsand contracting and releasing	*Increased use of space			Decreased use of space		
Movement * Limited to arm movements	Body-half Upper body	Vertical	*Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Spreading arms open to the sides					
Any movement preferences	If yes, describe: o Arm movements					
Facial expressions	Describe: o Smiling					
Other observations	o Overall more orientated movements o Improvised movement: Small arm movements, close to body o Structured movement: More expanded arm movements, but still soft; More open; Contract and release o Addsrhythm					

OBSERVATION SCHEDULE

Session: 7 **Theme: Holding back or helping** **Participant: D**

Shape * Improvised movement ** Structured movement	**Rising or sinking	Spreading or *enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	**Widening or narrowing
Effort * Improvised movement ** Structured movement	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: **Strong and *heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Forwards and backwards; Sideways)			Decreased use of space		
Movement * Limited to leg movement	Body-half Lower body	Vertical	*Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Walks					
Any movement preferences	If yes, describe: o Leg movement (Where her usual preferred movements are arm movements and turns = she is being hold back from what she would like to do. But even during the structured movement sequence she does not use her arms, because she does not feel comfortable with having others so close in her personal space)					
Facial expressions	Describe: o Uncomfortable and uncertain facial expression during both improvised and structured movement sequences					
Other observations	o Improvised movement: Can't move in space; Small, restricted movements; Turns around and walks away immediately after sequence is done o Structured movement: Bigger, stronger and more definite steps forwards and sideways; Still does not use arms – movement is limited to the lower body;Very hesitant to fall backwards					

OBSERVATION SCHEDULE

Session: 8 **Theme: From small to tall** **Participant: D**

Shape * Only during improvised movement	***Rising and sinking**	**Spreading and enclosing**	**Advancing and retreating**	Growing or shrinking	Lengthening or shortening	**Widening** or narrowing
Effort * Not to body, but in terms of using space and levels	Flow of movement: **free**	Flow of movement: ***bound**	Weight: **Light** and limp	Weight: **Strong** and heavy	Time: **Sustained**	Time: Sudden and quick
Space	**Increased use of space**(Slight up and down and sideways movements with lower body; Arms reach up high or out wide)			Decreased use of space		
Movement	Body-half	**Vertical**	**Horizontal**	**Cross-lateral**	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Hugging and rocking self ○ Contracting and expanding ○ Releasing ○ Shape of heart with hands					
Any movement preferences	If yes, describe: ○ Arm movements					
Facial expressions	Describe: Face is very expressive while executing structured movement sequence and includes frowning, clenching jaw and smiling					
Other observations	○ Improvised movement: Up and down; Arms in and out; Elaborate, sweeping movement with arms; Turn ○ Structured movement: Stronger and more definite movements; Elongated and expanded; Although still very aware of space around her, she is using more space than before as she changes directions and moves sideways; Very expressive in the way she hardens or softens a movement to convey emotion					

OBSERVATION SCHEDULE

Session: 9 **Theme: Salute to self-worth** **Participant: D**

Shape	Rising and sinking	Spreading and enclosing	Advancing or retreating	Growing and shrinking	Lengthening and shortening	Widening and narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Sideways; Lower and higher)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Expanding and contracting ○ Release ○ Forming heart with hands					
Any movement preferences	If yes, describe: ○ Hand and arm movements ○ Turns					
Facial expressions	Describe: ○ Smiling ○ Proud					
Other observations	○ Improvised movement: Big sweeping arm movements using levels and space; Expanding and contracting; Releasing, open movements; Movement varies in quality according to emotions: soft, more determined, definite and convincing ○ Structured movement: Movements are defined and extended and become more so with every repetition of the sequence ○ Freestyle movement: Strong, spontaneous movement but does not want to remain in the centre of the circle for too long					

Addendum R (5): Observation schedules of Participant E

OBSERVATION SCHEDULE

Session: 2 **Theme: Create Connection and Cohesion** **Participant: E**

Shape * Only when executing movement sequence	*Rising or sinking	*Spreading or enclosing	*Advancing or retreating	*Growing or shrinking	*Lengthening or shortening	*Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Keeps hands close to body in prayer position during majority of the session					
Any movement preferences	If yes, describe: Sweeping arm movements					
Facial expressions	Describe: Giggles a lot and jokes around					
Other observations	○ When receiving mirror, turns it in all different directions and tilts head from side to side ○ Hesitantto show movement sequence ○ Movements start small but then open up: "I want to love myself so I can love the world"					

OBSERVATION SCHEDULE

Session: 3 **Theme: Words Shape Me** **Participant: E**

Shape * Slight arm movements above head ** Small steps forward	*Rising or sinking	Spreading or enclosing	**Advancing or retreating	*Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Forwards and higher)			Decreased use of space		
Movement	Body-half Improvised: Upper body Structured: Lower body	Vertical	Horizontal Only slightly forwards	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: * Movements are very distinctive					
Any movement preferences	If yes, describe: * Movements are very original					
Facial expressions	Describe: o Wide grin o Hand in front of mouth when she makes a mistake o Giggles a lot and jokes around with other participants					
Other observations	o Dances and skips in between o Improvised movement: Small, close to body, but original(explosion) o Structured movement: Walks around (wide circles) and says she cannot think of a movement; Then creates a very energetic movementbut does not use a lot of space or wide range of body movement o Freestyle movement: Large, flowing movements, but very conscious whether someone is watching: When she thinks no one sees, she executes beautiful flowing movement and then stops and looks around to check if someone saw					

OBSERVATION SCHEDULE

Session: 4 **Theme: Feeling feelings** **Participant: E**

Shape * Improvised movement ** Structured movement *** Linking movement	Rising or *sinking	Spreading or *enclosing	**Advancing or retreating	***Growing or shrinking	***Lengthening or shortening	Widening or narrowing
Effort * Arm movements ** Linking movements (runs)	Flow of movement: **free	Flow of movement: *bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: * Very original movements used in each session					
Any movement preferences	If yes, describe: o Arm movements o Runs					
Facial expressions	Describe: o Grinning					
Other observations	o Bigger stronger warmup moves o Bigger more daring moves such as handstands when moving freely; uses more space o Improvised movement: Close to body and ground o Structured movement: Still close to body, small and limp arm movements slightly away from body; Limited use of space o Linking movement: Runs; Forward motion					

OBSERVATION SCHEDULE

Session: 5 **Theme: Rolling with role models** **Participant: E**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement:free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe:					
Any movement preferences	If yes, describe:					
Facial expressions	Describe:					
Other observations	**ABSENT**					

OBSERVATION SCHEDULE

Session: 6 **Theme: Personal progress patterns** **Participant: E**

Shape	Rising or **sinking**	**Spreading** or enclosing	Advancing or retreating	Growing or **shrinking**	Lengthening or shortening	**Widening** or narrowing
Effort	Flow of movement: **free**	Flow of movement: bound	Weight: Light and **limp**	Weight: Strong and heavy	Time: Sustained	Time: **Sudden and quick**
Space * Limited to arm movements and contracting and releasing	***Increased use of space**			Decreased use of space		
Movement	Body-half	**Vertical**	**Horizontal**	Cross-lateral	Sagittal	Core support
Any recurring patterns	If **yes**, describe: o **Throwing arms up into the air**					
Any movement preferences	If **yes**, describe: o **Arm** movements					
Facial expressions	Describe: o **Grinning** o **Arms folded** during most of the session					
Other observations	o **More confident** movement, but **not controlled** o Improvised movement: **Large horizontal and vertical arm movements**, but not extended because movements are **executed hurriedly**; **Vertical use of space through contracting and releasing** the upper body o Structured movement: **Executed haphazardly**, movement starts **small and close to the body** but then extends in the air, but the movement in itself is **limp and uncontrolled**					

OBSERVATION SCHEDULE

Session: 7 **Theme: Holding back or helping** **Participant: E**

Shape * Improvised movement ** Structured movement	**Rising or sinking	**Spreading or enclosing	Advancing or retreating	Growing or shrinking	**Lengthening or shortening	Widening or *narrowing
Effort	Flow of movement: **free	Flow of movement: *bound	Weight: **Light and limp	Weight: Strong and *heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Forwards and backwards; Sideways)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Rising ○ Turning ○ Sliding					
Any movement preferences	If yes, describe: ○ Rising, turning and sliding (Movements that allow to break free from other participants' restraints. Usual preferred arm movements return during structured movements sequence where movement is supported and not restricted = During improvised movement she felt held back from what she really wanted to do)					
Facial expressions	Describe: ○ Frowning during improvised movement sequence ○ Laughing during structured movement					
Other observations	○ Improvised movement: It is clear that participant wants to execute sweeping movements using space vertically and horizontally, but these movements are restricted by other two participants and instead come across as small and incomplete; Can't use space horizontally, so try to release through vertical movement which leads to narrowing of movement and as she is being pulled down, her movements seem heavy ○ Structured movement: Movements are elongated and extended; Clearly there is more freedom of movement; Lighter; Turn faster and slide further with the momentum provided by supporting participants; More daring movement ○ Free movement to music is open, fluent and daring					

OBSERVATION SCHEDULE

Session: 8 **Theme: From small to tall** **Participant: E**

Shape	Rising and sinking	Spreading and enclosing	Advancing and retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space (Extensive use of space and levels)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Contracting and expanding o Releasing o Falling down and getting up					
Any movement preferences	If yes, describe: o Sweeping arm movements o Turns * Each movement sequence executed during respective sessions contains something original and new. This time she used stomach isolations, a body ripple and sliding backwards (similar to a moon walk) – a very natural and talented mover indeed					
Facial expressions	Describe: Facial expressions are very interpretive of the movement she is executing: contractions are accompanied by frowning; expansions are supported by a smile or a look of relief					
Other observations	o Improvised movement: Body ripple down to the floor, jump up and moon walk backwards; Grande port de bras while turning and then falling down to the floor o Structured movement: More defined; Better extension; More interpretive; Up and down; Turn across the floor; Forwards and backwards; Arms at different levels and various open positions; Very original and creative use of levels, directions and space					

OBSERVATION SCHEDULE

Session: 9 **Theme: Salute to self-worth** **Participant: E**

Shape	Rising and sinking	Spreading and enclosing	Advancing and retreating	Growing and shrinking	Lengthening and shortening	Widening and narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Forwards and backwards; Sideways; Up and down; Higher and lower)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Contracting and expanding ○ Widening and narrowing ○ Rising and sinking ○ Release					
Any movement preferences	If yes, describe: ○ Sweeping arm movements ○ Turns					
Facial expressions	Describe: ○ Excitement ○ Smiling ○ Pride					
Other observations	○ Improvised movement: More independent movement; Sweeping, extended, open movements; Deep levels; Use expansive space; Deliberate, definedand yet graceful ○ Structured movement: Excited about new movement sequence; Tries out everyone else's movements when they share them; Exhumes confidence more and more as sequence is repeated and starts to add her own interpretation and rhythm to the movements ○ Freestyle movement: Strong spontaneous movement, Contagious enjoyment; Wants everyone to take part and enjoy it as much as she does					

Addendum R (6): Observation schedules of Participant F

OBSERVATION SCHEDULE

Session: 2 **Theme: Create Connection and Cohesion** **Participant: F**

Shape * Due to expressing anger	*Rising or sinking	Spreading or enclosing	*Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half Upper body	Vertical Very limited	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Punches					
Any movement preferences	If yes, describe: Arm movements					
Facial expressions	Describe: ○ Sighs a lot ○ Looks down a lot					
Other observations	○ Looks to others for correctness and affirmation ○ Walks away with mirror and looks at it apart from the rest of the group ○ Small movements, close to the body, executed quickly just to finish and fall back into the group ○ "I am angry because I don't like what I see in the mirror and there's nothing I can do about it"					

OBSERVATION SCHEDULE

Session: 3 **Theme: Words Shape Me** **Participant: F**

Shape * Slight arm movements above head and away from body centre	*Rising or sinking	*Spreading or enclosing	Advancing or retreating	*Growing or shrinking	*Lengthening or shortening	*Widening or narrowing
Effort * Limited to arm movements	Flow of movement: *free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement * Limited to arm movements	Body-half Upper body	*Vertical	*Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Showing tears running down cheeks (crying)					
Any movement preferences	If yes, describe: Arm and hip movements					
Facial expressions	Describe: ○ Looks down a lot; limited eye contact ○ Shrugs after executing movement sequences					
Other observations	○ Very concerned about others ○ Willing to go first ○ Hands on hips ○ Improvised movement sequence: Very fast execution; Floppy and incomplete movements; Small movements close to body; Hunched posture ○ Structured movement: More open, wider and more extended, away from body; More confidence, but still completed very quickly; Looks around to follow others ○ Freestyle movement: Small, uncertain, close to body, limp					

OBSERVATION SCHEDULE

Session: 4 **Theme: Feeling feelings** **Participant: F**

Shape * Improvised movement ** Structured movement *** Linking movement	Rising or *sinking	Spreading or *enclosing	Advancing or retreating	**Growing or shrinking	**Lengthening or shortening	***Widening or narrowing
Effort * Improvised movement ** Structured and linking movement	Flow of movement: **free	Flow of movement: *bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: Different movements from previous sessions which all indicated a pattern					
Any movement preferences	If yes, describe: o Arm movements					
Facial expressions	Describe: o Pouting o Arms folded, holds herself					
Other observations	o Participant feels excluded from the group because she is the youngest o Just sits, does not want to participate o Another participant makes an effort to include her o Improvised movement: Small, incomplete movements close to body; Self soothing moves; Hunched posture o Structured movement: Stronger; Jumps up using space vertically o Linking movement: Turns; Uses more space horizontally; Spread arms open					

OBSERVATION SCHEDULE

Session: 5 **Theme: Rolling with role models** **Participant: F**

Shape	Rising or sinking	Spreading or enclosing	Advancing or retreating	Growing or shrinking	Lengthening or shortening	Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space			Decreased use of space		
Movement	Body-half Upper body	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Hand movement indicating that she can't see					
Any movement preferences	If yes, describe: ○ Arm and hip movements					
Facial expressions	Describe: ○ Frowning while reading ○ Smiling when executing movement					
Other observations	○ Feels more accepted in smaller group ○ More willing to share movement ○ Improvised and structured movement: Bigger, stronger movements					

OBSERVATION SCHEDULE

Session: 6 **Theme: Personal progress patterns** **Participant: F**

Shape * Limited range of movement	Rising or sinking	Spreading or enclosing	*Advancing or retreating	Growing or shrinking	Lengthening or shortening	*Widening or narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space * Limited usewhen moving forward	*Increased use of space			Decreased use of space		
Movement * Limited to small steps forward	Body-half Upper body	Vertical	*Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: o Hiding face behind hands o Shaking head					
Any movement preferences	If yes, describe: o Arm and hip movements					
Facial expressions	Describe: o Frowning when hearing the word "choreography" o Very emotional but looking down while executing movement sequence					
Other observations	o Very expressive and yet comprehensible movement o Improvised movement: Small movements with arms close to body; Isolated head movement; Very emotional expression; Uses a little bit of space from left to right o Structured movement: Stronger arm movements; Move forwards using space vertically; Hands on hips; Exhumes more confidence towards the end of the session					

OBSERVATION SCHEDULE

Session: 7 **Theme: Holding back or helping** **Participant: F**

Shape * Improvised movement ** Structured movement	**Rising or sinking	Spreading or *enclosing	Advancing or retreating	Growing or shrinking	**Lengthening or shortening	Widening or *narrowing
Effort * Improvised movement ** Structured movement	Flow of movement: **free	Flow of movement: *bound	Weight: **Light and limp	Weight: Strong and *heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space (Forwards and backwards)			Decreased use of space		
Movement * Improvised movement ** Limited to arm movements	*Body-half Lower body	Vertical	**Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Walks					
Any movement preferences	If yes, describe: ○ Leg movement (which is not usually her preferred movement = being held back from doing what she wants to do. When supported in structured movement sequence, she reverts back to arm movements)					
Facial expressions	Describe: ○ Angry and frustrated during improvised movement sequence ○ Laughing and smiling during structured movement					
Other observations	○ Improvised movement: Restricted range of movement; Stoic and uncoordinated; Can't use arms; Movement becomes aggressive ○ Structured movement: Move forwards and backwards; Opens arms; Fall forwards as if flying; States that she feels safer and more graceful when participants act supportively ○ Free movement to music more daring (leap), extended and strong					

OBSERVATION SCHEDULE

Session: 8 **Theme: From small to tall** **Participant: F**

Shape	Rising and sinking	Spreading and enclosing	Advancing and retreating	Growing and shrinking	Lengthening or shortening	Widening and narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Not very expansive but moves forwards and backwards; Up and down; Sideways)			Decreased use of space		
Movement	Body-half	Vertical	Horizontal	Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Hugging / shielding self ○ Shaking head ○ Contract and expand ○ Release					
Any movement preferences	If yes, describe: ○ Arm movements					
Facial expressions	Describe: Very expressive: Shows anger, determination, joy and reliefas movement sequence progresses					
Other observations	○ Improvised movement: Unsure of the meaning of some of the words which temporarily affects the strength and definition of her movement, but after clarification she rises on her toes; Opens her arms upward and sideways; Crouch down and fold arms in close to her body; Contract and compress ○ Structured movement: Choose too many words, so got confused or forgot, but still a very original and expressively executed structured movement piece; Strong, defined and original movements using space vertically and horizontally; Overall movement is more orientated, focused and self-assured					

OBSERVATION SCHEDULE

Session: 9 **Theme: Salute to self-worth** **Participant: F**

Shape	Rising or sinking	Spreading and enclosing	Advancing or retreating	Growing or shrinking	Lengthening and shortening	Widening and narrowing
Effort	Flow of movement: free	Flow of movement: bound	Weight: Light and limp	Weight: Strong and heavy	Time: Sustained	Time: Sudden and quick
Space	Increased use of space(Away from the body, but not traveling)			Decreased use of space		
Movement * Limited to arm movements	Body-half	*Vertical	*Horizontal	*Cross-lateral	Sagittal	Core support
Any recurring patterns	If yes, describe: ○ Spreading and enclosing ○ Widening and narrowing					
Any movement preferences	If yes, describe: ○ Hand and arm movements					
Facial expressions	Describe: ○ Determined					
Other observations	○ Improvised movements: Moves are no longer floppy, but stronger and more definite; Use of space is more limited than previous session, but she stated at the beginning that she is experiencing menstrual pains which might make movement uncomfortable; Arm movements still vary in application of levels and space ○ Structured movement: Exhumes more confidence; Does not looks around at others for confirmation as much ○ Freestyle movement: At first a bit uncertain, but after seeing others go into the centre and dancing, she dares to do the same and enjoys it a lot; Strong and rhythmic movements					

Addendum S: Summaries of observation schedules

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 2 OBSERVATION SCHEDULES

DATE: 21 August 2018 **THEME: Create Connection & Cohesion**

Uncertain movement: small, restricted, limited use of space	Preferred movements
More confident movement: increase, opening and releasing, more use of space	Facial expressions
Patterns	Other observations

SHAPE	○ 4/6 Participants movements are limited ○ Sinking, enclosing, retreating, shortening, shrinking and narrowing ○ 2/6 start to increase range of movement as session progresses to include spreading, advancing, lengthening and widening
EFFORT	○ 3/6 participants' movement quality is bounded, limp and quickly executed ○ 1 participant's movements were free and light but also sudden and quickly executed ○ The other participant's movement quality was still bounded and rapidly executed, but the movements were

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 3 OBSERVATION SCHEDULES

DATE: 23 August 2018 **THEME: Words Shape Me**

Uncertain movement: small, restricted, limited use of space	Preferred movements
More confident movement: increase, opening and releasing, more use of space	Facial expressions
Patterns	Other observations

SHAPE	○ 5/6 Participants' movements are slightly increasing in terms of range of movement ○ Arms spreading, lengthening and widening slightly above head ○ Slight arm movements away from body centre ○ Small advancing steps
EFFORT	○ 3/6 participants' quality of movement has developed from being limp to being light ○ The movements of the two participants which can be described as being more free than bounded are still limited, but are more progressed in this sense when compared to the other participants' movements
SPACE	○ 3/6 participants' still avoid using the space around them ○ 3 other participants' did engage in movements that slightly extend into the immediate space around them

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 4 OBSERVATION SCHEDULES

DATE: 28 August 2018 **THEME: Feeling feelings**

*** Participant C is absent**

Uncertain movement: small, restricted, limited use of space	**Preferred movements**
More confident movement: increase, opening and releasing, more use of space	**Facial expressions**
Patterns	**Other observations**

SHAPE	○ **4/5 Participants' movements are showing an increase in range of movement when doing structured movement** ○ **Improvised movement sequences are still marked by limited range of movement**
EFFORT	○ **3/5 participants' quality of movement has developed from being executed quickly and suddenly to reflect sustained movement** ○ **4/5 participants now exhibit more free than bounded quality of movement although these movements are limited to arm movements and characteristic of structured movement sequences**
SPACE	○ **All 5 participants now show an increased use of space – however slight**
MOVEMENT	○ **All 5 participants now execute movements which use space**

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 5 OBSERVATION SCHEDULES

DATE: 30 August 2018 **THEME: Rolling with role models**

* Participant B, C and E are absent

Uncertain movement: small, restricted, limited use of space	Preferred movements
More confident movement: increase, opening and releasing, more use of space	Facial expressions
Patterns	Other observations

SHAPE	○ 2/3 Participants' movements are showing an increase in range of movement when doing structured movement ○ Improvised movement sequences are still marked by limited range of movement ○ An increase in the range of movement of the other participant is evident in both improvised and structured movement. ○ She mentioned that she feels safer and more accepted in the smaller group which might be the reason for the above
EFFORT	○ All three participants display stronger and more definite quality of movement ○ All three participants' movements are still sudden and quick ○ 2/3 participants still display a bounded quality of movement,

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 6 OBSERVATION SCHEDULES

DATE: 4 September 2018 **THEME: Personal progress patterns**

Uncertain movement: small, restricted, limited use of space	**Preferred movements**
More confident movement: increase, opening and releasing, more use of space	**Facial expressions**
Patterns	**Other observations**

SHAPE	○ All 6 Participants' movements are showing an increase in range of movement when doing structured or improvised movement ○ 4/6 Participants' movements are showing an increase in range of movement when doing both structured and improvised movement ○ Only one participant increase in range of movement can still be described as limited when compared to the other participants
EFFORT	○ 4/6 participants' movements can be described as stronger ○ 5/6 participants' movements reflect a more free characteristic ○ 2 participants' movements are still bound when executing either improvised movements or both improvised and structured movement respectively ○ 2 participants' movement still have a limp and unfocused

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 7 OBSERVATION SCHEDULES

DATE: 6 September 2018 **THEME: Holding back or Helping**

*** Participant C is absent**

Uncertain movement: small, restricted, limited use of space	**Preferred movements**
More confident movement: increase, opening and releasing, more use of space	**Facial expressions**
Patterns	**Other observations**

SHAPE	○ All 5 Participants' movements are showing an increase in range of movement when doing structured movement ○ All 5 Participants moved forward during structured and improvised movement ○ 4/5 Participants exhibited shrinking, enclosing or narrowing movements during improvised movement, but this was due to the other participant restricting their movement
EFFORT	○ 2/5 participants' displayed strong movements as they attempted to break free from the restraining participants ○ 4/5 participants' structured movements reflect a more free and light characteristic ○ All five participants' improvised movements were bounded and heavy due to the nature of the

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF SESSION 8 OBSERVATION SCHEDULES

DATE: 11 September 2018 **THEME: From small to tall**

*** Participant B & C are absent**

Uncertain movement: small, restricted, limited use of space	**Preferred movements**
More confident movement: increase, opening and releasing, more use of space	**Facial expressions**
Patterns	**Other observations**

SHAPE	○ **All 5 Participants' improvised as well as structured movements have increased in range to include a variety of body shapes and movement patterns** ○ **Small movements are not used express low self-esteem, but to include different levels and use of space in their movement sequences**
EFFORT	○ **All 5 participants' movements can be described as free, light, strong and sustained** ○ **One participant's movement still holds a bounded quality, but not in terms of body movement but with regards to use of space** ○ **Her bounded movement is due o feeling uncomfortable when others enter her personal space**
SPACE	○ **All 5 participants have ventured further into the space around**

Addendum T: Completed process notes in the researcher's diary

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 2 DATE: 21 August 2018 THEME: Create Connection & Cohesion

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. Hand out personal DMT journey Journals: Participants seem unsure and nervous o look around o giggle o fidget with hands and/or clothing 2. Hand out, explain and sign of confidentiality agreement: Some participants say they do not have a signature yet I let them write their names in printed capital letters 3. Participants complete second session check in page: Participants ask many questions before completing check in page Even though box of crayons is set out, participants ask if they may use them Very formal. Sit on chairs.	**Brainstorming** *Search for supporting literature* *Could having a signature play a role in identity formation and subsequent level of self-esteem?* *Fear of doing something wrong; need for approval?*

	4. Design code of conduct: Facilitator suggests rules that are purely organisational Participants suggestions are all centred around protecting themselves emotionally (cf. Addendum R) 5. Warm-up exercises are done to prepare muscles for executing movement Participants look at each other and facilitator to see if they are doing executing movements correctly. Movements are small and not fully executed. Participants are very aware of space around them. Automatically move away from each other when circling arms. 6. Stimulus: No one wants to look in the mirror. Facilitator has to go first. 7. Improvised and structured movement: Improvised movement: ○ No one wants to go first. ○ Movements are generally small and close to the body. Movements are executed quickly to be able to return to the group.	*Suggests the degree of vulnerability with regards to self-esteem* *Instinctively afraid of getting hurt? Corresponds with supporting literature about spatial awareness of children with low vision* *Emphasises how self-conscious participants are* *Indicative of limited self-confidence, fear of the unknown and need to experience independent success*

	Structured movement: ○ Participants show more self-confidence when doing movement as a group. ○ Movements become stronger and more defined with each repetition as they experience more success 8. Choosing a name for the group: Participants all feel the name should include the word *mix* because… ○ "*…we are feeling all kinds of feelings…they are all mixed up…*" ○ "*…we are all look different from each other…we are all different from each other...*" They then decide on *Starlight Mix* because… ○ "*…no one knows how bright we can really shine until a person gets close enough to know us…*" ○ "*…we feel like our brightness is far away…out of reach…*" ○ "*…if we could get the chance and have the courage to shine, we will be brilliant…*" 9. Cool down with breathing and stretching exercises Participants giggle when they have to do deep breathing exercises.	*as literature suggests* *Possibly trying to cover up their feeling of vulnerability with giggling*

	10. Reflection in DMT Journey Journals: More relaxed. Lie or sit on the floor. Still ask a lot of questions before writing reflections. No one wants to share reflections yet. 11. Consolidation and closing session Participants learn to curtsey.	*Fear of failure; need for approval?*
Any relation to literature studied? (Incl. references for easy referral) **and / or** **Suggestions about further reading…**	○ Fear of space ○ Fear of the unknown ○ Need to experience feeling independent and achieving success ○ Body language indicative of low self-esteem ○ Does having a signature contribute to identity formation and feeling of self-worth?	
Ideas to follow up on **and / or** **Questions to explore further…**	○ Meaning or reason for curtsey/bow at the end of a dance class or performance	
Personal views and opinions	Participants all agree on… ○ …feeling different than people with a normal vision spectrum, ○ …not having chance to shine ○ …gives a sense of camaraderie	

Problem analysis **What was useful (good) / not useful (bad)?**	**Use:** ○ Confidentiality agreement ○ Code of conduct	**Disregard:**	
Any other relevant information	Need to manage time better. Session took 15 minutes longer than planned.		

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 3 **DATE: 23 August 2018** **THEME: Words Shape Me**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. Handing out of DMT Journey Journals: Participants want to know whether I read their reflections and whether they did it right. I remind them that there is no right or wrong, because it is how they feel	**Brainstorming** *Fear of failure; need for approval*

	and what they think. 2. Third session check in: Participants seem more comfortable. Go fetch the box of crayons themselves. Ask if they can indicate other emotions than those given on the list. 3. Sign, file and display of code of conduct: Participants want to know whether the code of conduct is going to remain on the wall where they decided to display it. I explain that other people also use the venue, so we will remove it after each session for confidentiality purposes, but that I will ensure that it is visible during each session from here on out. 4. Display of group name: Participants formed a *whatsapp* group with their group name and designed four possible profile pictures / logos that displays the group name "*Starlight Mix*". 5. Warm up: Less looking around at each other and more focused on the exercise itself. Movements in general seem more controlled.	*More independent, more willing to step out of comfort zone* *Need for reassurance* *Indicative of group cohesion being established* *Know they can do it, so feel more capable*

	6. Stimulus: Participants try to hide the negative feedback they write down (holding their hands or arms over their words; lying over the paper) They want to pass their paper on to the person they know best, rather than to the person sitting next to them. Participants are very surprised when they read the positive feedback they received from their peers. 7. Improvised and structured movement: Participants are more willing to share their movement expressions and willing to help and encourage each other. Movements expressing feelings generated from negative feedback are generally small and executed close to the body, while movements expressing feelings evoked from positive feedback are more open and definite. Movements are most defined and extended during the group movement sequence.	*Indicative of low self-esteem* *Suggests growing group cohesion and mutual trust* *Indicative of effect of negative vs positive feedback* *Still feel safer in a group*

	8. Reflection in DMT Journey Journals Participants continue more independently with the reflection process. They seem to be more settled now, lying comfortable on the floor while writing in their journals (like teenagers lying on their bed while writing in their diaries) They seem more comfortable with and trusting towards each other as they make jokes and laugh in between. 9. Consolidation and ending of session I explain the reason why dancers curtsey or bow after dance class and dance performances. It is to acknowledge and thank those who support you. The relevance of this action is even more fitting for the end of a DMT session. Participants perform the curtsey with more verve after comprehending that they are thanking each other for witnessing and supporting their journey. The movement in itself is also more coordinated and definite as they are executing it for the second time.	*Starting to feel capable and able* *Growing group cohesion* *Knowing that they are each other's witnesses and supporters seems to boost their self-confidence* *Feeling more able and capable adds to self-esteem*

Any relation to literature studied? **(Incl. references for easy referral)** **and / or** **Suggestions about further reading…**	○ Acting independently boosts self-esteem ○ Experiencing failure or success has an impact on self-esteem ○ Need to see that they are able to do things ○ Effect of negative feedback on self-esteem ○ Feeling needed boosts self-esteem ○ Why do people with low self-esteem hide within the group? ○ Role of trust in building self-esteem	
Ideas to follow up on **and / or** **Questions to explore further…**	Perhaps hand out an abbreviated and adapted information page about reflection (what it means, what it entails etc.) so as to increase a client's understanding of the process and to assure the client that his / her answers will not be judged or considered to be correct or incorrect.	
Personal views and opinions	Participants' self-esteem is clearly adversely affected by negative feedback and although it seems like normal "teenage insecurities" such as friendship, relationships with the opposite sex or body image, there is an added element of origin leading up to their feelings of insecurity that connects to all of the afore mentioned: the fact that they have low vision.	

Problem analysis **What was useful (good) / not useful (bad)?**	**Use:** Shape as a stimulus for movement	**Disregard:**	
Any other relevant information	Participants seem more nervous and unsure at the beginning of a session than at the end. Perhaps, when it is purely therapeutic and not part of a research setting where data can be compromised, the facilitator can give a brief framework about what the next session will entail so as to make the client feel more prepared.		

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 4 **DATE: 28 August 2018** **THEME: Feeling Feelings**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1.Handing out DMT Journey Journals: While handing out the journals I remind them that their feelings and thoughts are not judged as right or wrong, that their feelings and thoughts matter and I	**Brainstorming** *To ensure sense of*

	compliment them on how their reflection skills have developed between the first and second session. 2. Displaying group name and code of conduct: I focus the participants' attention on the fact that I took both the group name and code of conduct down at the end of the previous session and that I am putting it back up while they are checking in. 3. Complete fourth session check in: A few of the participants are sick with flu and indicate that on their check in page. 4. Warm up It seems that the participants are now familiar with the warm up exercises. I state that I can see they know what to do and what to expect and that I am going to add one or two additional exercises to keep challenging them because I know they are capable of doing it. I add one aerobic and one strengthening exercise to the warm up sequence.	*acceptance* *To ensure sense of security* *Read up on how being physically ill influences self-esteem* *To continue challenging them so they continue experiencing transcendence of what they think they can't do and*

		experience success
	5. Stimulus: Participants mention how they always struggle to explain how they feel or understand how others feel because they can't always see other's facial expressions and that it makes it easier to describe when comparing something you cannot see to a tangible texture that everyone is acquainted with and which they can access at the same level as everyone else. They are very excited to share this skill with their blind peers.	*In line with supporting research* *Feel needed and able to help others*
	6. Improvised and structured movement: One participant is absent due to Tonsillitis and I as the facilitator have to stand in when the group breaks into groups of three. One participant has distanced herself from the rest of the group and stops participating. She feels inferior to some of the other participants as she is the youngest. Another participant sees me talking to her and tries to comfort and include her.	*In a purely therapeutic setting, one might only include clients of the same age to avoid this from happening.*

	Participants create quite original movements to mimic their feeling feelings textures. Once again the movements representing the feeling of failure are small and close to the body, contracted and hunched whereas the movements representing the feeling of success are more extended, elongated and open. The intervening movements the participants create for one another to move each other away from failure towards success generally symbolizes support and encouragement and encourages more open, grander and sweeping movement using space. 7. Reflection and closing the session Before reflection, I read the code of conduct again as a subtle way to remind participants to treat all group members as their equals. I focus on the similarities between participants so as to move away from the age difference.	*Size of movement supports researched literature.* *Suggests the relevance of Session 7: Holding back or helping* *Read up on how being the youngest in a group can affect self-esteem*
Any relation to literature studied? (Incl. references for easy referral)	○ Research with regards to persons with low vision finding it challenging to interpret facial expressions and other signs of body language. ○ Research regarding how persons with low vision's self-esteem is affected by experiencing failure due to their eye sight and how they need to be	

and / or **Suggestions about further reading…**	trusted to act independent so they can experience more moments of success. ○ Research indicating that there is a difference between supporting and encouraging a person with low vision and helping a person with low vision because they are considered disabled. ○ Research indicating a person with low vision's need to feel needed and important. ○ How being physically ill can affect your self-esteem ○ How being the youngest in a group can affect self-esteem	
Ideas to follow up on **and / or** **Questions to explore further…**	When DMT is used for purely therapeutic reasons, it might be considered to keep the group homogenic with regards to age.	
Personal views and opinions	○ I can comprehend that being younger than other group members might make a participant feel less experienced and less competent. ○ I think due to our technological age, the youth of today have a limited emotional IQ and being able to explain an abstract concept like an emotion is made easier by describing it as something concrete and I believe being able to express yourself better can very well build on a person's self-esteem. ○ Lastly, I think it is good for adolescents to realise that there needs to be a balance between the effort you put in to achieve success and the support	

<table>
<tr><td></td><td colspan="2">and encouragement you need to get to make the most of that effort. It seems that the South African youth of today are on either of the two extremes – having to do everything on their own because there is no parental or family involvement or having the expectation that you can get everything you want by doing nothing but protest or begging for it.</td><td></td></tr>
<tr><td>Problem analysis
What was useful (good) / not useful (bad)?</td><td>Use:
Different tactile textures
Intervening movement from other group members</td><td>Disregard:</td><td></td></tr>
<tr><td>Any other relevant information</td><td colspan="2">The session was a bit less structured because I had to take part in the one group and was then not able to facilitate the other at the same time. The same can be said for when I tried to listen, support and re-engage the participant who had withdrawn from the session. Within a purely therapeutic session it might be a good idea to have two facilitators guiding the session for when “life” happens.</td><td></td></tr>
</table>

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 5 **DATE: 30 August 2018** **THEME: Rolling with Role Models**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. Handing out DMT Journey Journals and completing check in page for the fifth session: Three participants are absent due to the flu. The three participants who are present seem more at ease, spontaneous and willing to share. The participant who felt inferior to other participants indicates that she feels more accepted and at ease. 2. Warm up and stimulus: Upon asking, participants admitted that they did not know of other people with low vision that they can look up to. All three participants aspired to be like their mothers and/or older sisters, but that these individuals did not have low vision. All three participants associated with Thando Hopa because she was from South	**Brainstorming** *Perhaps, in a purely therapeutic setting a group of no more than four might accommodate the clients better* *Aligns with research literature* *Try to find more*

	Africa. The other role model each participant associated with was based on a shared passion such as singing, writing or acting. 3. Improvised and structured movement Participants enjoy the game of charades. It brings home the fact that movement really is part of our everyday lives. Participants seem more eager and willing to share their movement they created for their fellow participant – possibly because it is not the sharing of their own personal feelings but rather the chance to mean something to someone else and make a worthwhile and acknowledged contribution to someone else's life. Movements are starting to expand – moving away from the centre body and utilizing more space	*South African role models with low vision for future implementation. Add video and audio information about the individuals for future implementation* *In line with research literature*

	4. Cool down and reflection process More personal, detailed and in-depth due to smaller number of participants.	
Any relation to literature studied? (Incl. references for easy referral) **and / or** **Suggestions about further reading…**	○ Lack of role models who have also been diagnosed with low vision and how it effects self-esteem and psychosocial wellbeing ○ Person with low vision's need to feel like they are needed and / or is capable of making a valuable contribution to society ○ Research the importance of a role model originating from the same background as you ○ The impact of a lack of South African role models on South African youth ○ The appropriate group size for group therapy with person's with low self-esteem ○ Read up on the role that shared interests, passions or goals play in choosing a role model ○ Does adding video and audio technology make information more accessible and relevant for today's youth?	
Ideas to follow up on **and / or** **Questions to explore further…**	Perhaps present information about role models as a Power Point presentation with notes as an additional source. One of the school's classrooms could be used for this so that the presentation can be displayed on the monitors that are allocated to each desk so that information presented on the screen can be enlarged and enhanced.	

<table>
<tr><td>Personal views and opinions</td><td colspan="2">Now that I am looking at the situation from a more objective stand point, I realize that there individuals who work at or matriculated from this particular institution who can be considered to be role models with low vision:
Teachers who have degrees in education and music
Students who are currently in their final years of studying degrees such as performance art, law and business.
Parents of learners who also have low vision who serve as prime ministers or who have successful private businesses.
Including these examples and perhaps asking one or two individuals to engage in interviews which could be video recorded or to video record shots, personal motivational messages from these individuals can add to the efficacy, relevance and staying power of this intervention.</td><td></td></tr>
<tr><td>Problem analysis
What was useful (good) / not useful (bad)?</td><td>Use:
Information about role models
Charades
Structured movement sequence</td><td>Disregard:
Should the group be complete (6 participants), each participant will only choose one role model – not two as it seemed to confuse participants at one stage.</td><td></td></tr>
<tr><td>Any other relevant information</td><td colspan="2">Take reading speed and degree of vocabulary into consideration and adapt which ever reading pieces selected accordingly.</td><td></td></tr>
</table>

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 6 **DATE: 4 September 2018** **THEME: Personal Progress Patterns**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. Recap: I point out that we are half way through our journey and ask if the participants want to share anything about what they have experienced so far: ○ Participant A mentions that she feels closer to the other group members. ○ Participant C says that she felt "torn" at the beginning of the intervention programme but that she can feel that she is starting to "heal". ○ Participant D states that she is learning how to "trust" the truth in other people's positive verbalisations and how to "let go" of persons' negative words. ○ Participant E wants to know whether this programme will continue for others learners after they have completed it and if it means they cannot participate again. Other participants agree and say they will come to assist to show others what to do. ○ Participant F admits that she was very "scared" at the commencement of the intervention programme, but that she is starting to "believe" in herself a	**Brainstorming** *Indicative of how low initial levels of self-esteem have been*

	bit more every day. 2. Warm-up: I again add an additional aerobic and strengthening exercise to the warm-up sequence to challenge the participants. They enjoy the aerobic exercise, but complain a bit when the strengthening exercise starts to work their muscles. They are however very impressed with themselves after showing determination and finishing the exercise – some express out loud that they didn't think they could make it. 3. Stimulus: When explaining that each participant must think of a personal weakness and a personal strength, they exclaim that they learnt about strengths and weaknesses in Personal and Social Wellbeing (PSW) as part of the subject Life Skills. 4. Improvised and structured movement: I need to explain what choreography is as well as why and how it is done.	*Are becoming more adapted to challenges, but still do not believe in ability to succeed in the challenge* *Perhaps combine this programme with PSW and Physical Education (Movement) curriculum.* *Maybe add an instructional video of how*

		choreographers choreograph their work or a few examples of what choreographic design looks like
	Some participants' choreography is all indicated on one side in the top corner of the page. Those particular participants' movements correlate with what they created on paper: small, narrow movements staying more or less in one place.	*Suggests fear of space as literature stated. Suggests the relevance of Session 8: From small to tall. E*
	6. Reflection and end of the session: Reflection is now done independently and with much greater confidence. The same goes for the curtesy at the end of the session. I have them now voice the meaning of the curtesy movement as they execute it:	*Reaffirm movement through vocalisations*

	"I thank you and I acknowledge you".		
Any relation to literature studied? (Incl. references for easy referral) and / or Suggestions about further reading…	○ Feelings and thoughts associated with low self-esteem ○ Fear of space and the unknown ○ Study Life Skills curriculum (PSW, PE and even Creative Arts) to see if the intervention programme might be incorporated in the curriculum.		
Ideas to follow up on and / or Questions to explore further…	Gathering visual and audio explanations of choreography and perhaps present this in another Power Point Presentation		
Personal views and opinions	When looking back on sessions thus far, each session not only refers to psychological development but progression in social development as well – thus confirming that self-esteem is not something that improves or proliferates in isolation, but that it is indeed a significant aspect of psychosocial wellbeing		
Problem analysis What was useful (good) / not useful (bad)?	**Use:** Personal strengths and weaknesses Patterning	**Disregard:**	

Any other relevant information	Perhaps try the patterning process with paint or even finger painting in the future to include more sensory stimulation.	

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 7 **DATE: 6 September 2018** **THEME: Holding back or Helping**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. Seventh session check in: Participants are sharing more during the check in sessions. After the previous session they collaborated each participant's pattern movement sequence to choreograph their own movement piece. They are quite upset that one participant is absent again. They are concerned that she is not going to benefit as much from the programme as they are.	**Brainstorming** *Radiating more confidence* *More willing to act independently* *More daring than a whatsapp group and*

		profile picture *Established group cohesion and trust* *Suggest frustration or irritation* *In a purely therapeutic session, two facilitators will certainly be more effective to ensure efficacy of what is being presented in the session* *In line with researched literature*
	2. Stimulus and improvised movement: Lots of frowning going on. Even some clenching jaws. Presentation of the stimulus is again not as structured as I would like it to be, as I am standing in for one of the participants again when the group divides into two groups of three. I am not able to facilitate the other group as I am participating in the exercise. After the stimulus I ask this question: How do people treat you when they know you have low vision? "They think you can't do anything for yourself"; "They think we are going to get hurt if they are not there like all the time"; "They want to do everything for us"; "They say I won't be able to drive to work one day" Next question I pose: How does this make you feel? "Like I felt just now"; "Like being stuck"; "Like I am carrying everyone else with me – it feels heavy, like I felt now when we were moving"; "Frustrated, like I did now when we tried to move together"; "Like someone is holding on to me and I have to drag them with me – sort of like now when I had to move with my sisters holding on to me"	

	3. Stimulus and structured movement: Once again, I would've liked to facilitate the process more. Participants were playing and joking around in between their respective turns. On the upside, they were experimenting with spontaneous movement which suggests their growing confidence in moving without guidance and using it as a means of self-expression. With regards to the ending movement, it was clear that trust has certainly developed but that the extent of this differs for each participant as some executed more daring movements than others. It can also be due to the fact that they weighed in on their own and the other group members' ability to support their body weight. After the structured movement sequence, I present them with this question: How did you feel this time around? "I felt more able to move this time. The previous time they were holding me back"; "If it makes sense: I had more freedom but also more control"; "I could do what I want, but I knew they were there"; "I felt like I could fly because I felt safe to try what I wanted to do"; "I could do more knowing that they were there if I needed them. My arms didn't get tired and I could lift my leg higher" Lastly I asked them: How do you think this relates to how you want to be treated regardless of your low vision? "I want to make my own mistakes; I want to learn, but I want to know people will be there for me if I ask"; "We can do things on our own but we need encouragement and support"; "It's like when I am running the 1500m – I can do it	*Still recommend a second facilitator, but only to step in when he/she sees the process is completely derailing.* *In line with studied literature*

	on my own, but I feel I don't get tired so quickly if people are on the side cheering me on"; "I want the freedom to fly, to chase my dreams but I need others to motivate me and be there when I come back"; "I feel safer to take risks if I know there are others who support me in trying and who will pick me up if I fall" **4. Reflection and closure:** Reflection happens naturally and independently now. A few participants (Participant A, B and F) are also willing to share their reflections with the group.	*Experience of success* *Group trust and cohesion*
Any relation to literature studied? (Incl. references for easy referral) **and / or** **Suggestions about further reading…**	○ Research stating that family and or community members do everything for a person with low vision and subsequently keep them from making valuable contributions to the household or society and thus robbing them of experiencing success and having a sense of self-worth ○ Extend on above research as it is clearly a serious issue for all participants ○ Read up on the value of allowing spontaneous movement during DMT sessions	
Ideas to follow up on **and / or** **Questions to explore further…**	Perhaps use props such as ribbons and hoops in future sessions as there was one group member who did not like to be touched and have others come into her personal space. All of these items are available at the school to use in the Physical Education curriculum. There are also cones which could represent other obstacles.	

Personal views and opinions	It is human nature to want to help someone who is not as able at something as you are. Every teacher starts teaching at this institution with the feeling that he/she feels sorry for the learners and wants to do everything for them until they realise how adept most of them are. But if teachers feel this way, how much stronger must this feeling be for a parent or close family member and how must a community member who only sees the person from afar come to the realisation that they are able? This is not even considering the cultural and religious stigmas which are involved in South Africa's frame of reference. Thus in my opinion, this is a very relevant and serious issue which should be addressed through family and community psychology.		
Problem analysis **What was useful (good) / not useful (bad)?**	**Use:** Improvised and structured stimulus and movement sequence	**Disregard:** Human touch. Consider using props like ribbons and hoops	
Any other relevant information	Perhaps also use gymnastic mats to make participants feel safer when doing the final movement in the structured movement sequence.		

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 8 **DATE: 11 September 2018** **THEME: From Small to Tall**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. 5 Minute recap: Two participants mention that it is a stressful time as they are completing third term assessments and that they have started doing the cool down stretches and breathing exercises at night before bath time and that they then feel more relaxed and able to study. I congratulate them on taking initiative of applying the skills they learnt during this programme and advise them that stretching exercises are even more effective after bathing as their muscles are warmer then.	**Brainstorming** *I will give them an instructional handout of possible stretches and relaxation exercises at the end of this programme so they can continue stretching and progressively advance to more*

		challenging stretching exercises
	2. Stimulus and improvised movement: Some of the participants asked me to explain higher order words such as "confined", spacious", "cramped", "expanded" and "contracted".	*It might deem valuable to provide descriptive pictures along with the words as explaining the words through movement might tinge the originality of participants' ideas*
	3. Stimulus and structured movement: The majority of participants selected only a few relevant words and constructed their movement piece in time, but one or two wanted to use all the words and time caught up with them, which caused them to feel pressured, which is not	*In a purely therapeutic setting, it might help clients to*

	conducive to sustaining an accepting and secure environment. I acknowledge that some of the words are not used in everyday language and I explain the words to them as best I can without giving them movements to mimic. The improvised movements which they create do not only speak of understanding but also of originality. Movements are more expanded, elongated and open in general. All participants	*focus their thoughts, feelings and energy by presenting them with all the words at the end of the previous session (Session 7) and asking them which are most relevant to them. The list of indicated words can then be used to choose from during Session 8* *Importance of*

	use more space and vary the level of their movements more than before. Some participants are more comfortable with using space and levels than others. It could also have to do with the range of movement with which their bodies feel comfortable. Those who I have observed to be more supple when doing warm-up and cool down exercises do seem more comfortable with spreading out in to space, enlarging their movements and moving between lower and higher levels. On the whole, all of the structured movement sequences speak of a release; of liberation. Participants found the idea of removing the "dis-" from "disability" very significant. They have never conceived that when this prefix is removed, all that is left is ability.	*detailed, continuous observation, taking process notes and recording sessions.* *When practiced in a therapeutic setting it might have even more impact to structure a short group movement piece around this idea where props such as rope, ribbon or hoops are used to illustrate the*

	4. Reflection and consolidation of the session: Participants enquire whether they can keep the structured movement piece which they have created on paper because it reminds them of how far they have come and how much they have grown. I confirm that it will be filed in their DMT Journey Journal which they will receive back to keep at the end of the next session.	*break in the link between "dis-" and "ability".* *Need for validation, possible fear of regressing back to previous level of self-esteem*
Any relation to literature studied? (Incl. references for easy referral) **and / or** **Suggestions about further reading…**	○ Relevance of process notes and researcher's diary ○ Importance of independent actions and experiencing success ○ Fear of uncertainty ○ Fear of space ○ Read up on the power of words such as "disability" and "ability" ○ Research the impact of limited vocabulary on self-esteem and psychosocial wellbeing	
Ideas to follow up on and / or Questions to explore further…	○ Compile a "movement handbook" with warm-up, spontaneous movement and cool-down exercises to give participants so they can continue using the skills they learnt during this programme well after the intervention has	

	been terminated. ○ Put together a power point presentation with cartoon images that explain the terms used to stimulate the improvised movement sequence. This will not only make it more fun, but will inform the participants beforehand what each word means so that they do not feel inadequate when they choose their stimulus concepts and then realise that they do not know what they mean.		
Personal views and opinions	The importance of observing every participant individually during every session from start to finish was emphasised during this session as physical ability and personal progress had to be considered when evaluating the structured movement sequence. I think the recording of such sessions is invaluable for this very reason as it allows the facilitator to go back, compare and pick up small details which might have been missed originally. This enabled me to see that all participants have made progress in trusting the space around them, while when looking at this session in isolation, it might seem as if some participants have not made any gain at all.		
Problem analysis **What was useful (good) / not useful (bad)?**	**Use:** ○ The stimulus and subsequent improvised movement ○ The stimulus and subsequent structured movement	**Disregard:** The stimulus for the improvised movement need not be disregarded but needs to be better explained prior to implementation	
Any other relevant information	Before participants start with the structured movement session, they need to be reassured that they will get to keep the movement piece they put together as a		

	reminder of their journey. It might even motivate them to add value, honesty and detail to it if they know beforehand that they will be able to refer back to it when they need a reminder of how capable they are.	

DANCE / MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SESSION: 9 **DATE: 13 September** **THEME: Salute to Self-Worth**

RESEARCHER'S DIARY

Process notes		
Report on what was observed (summary of what was done and said)	1. Session 9 check in: Participants say it's very sad that we are putting up the group name and code of conduct for the last time. One participant says she wishes they could take the code of conduct out into real life. The other participants agree that it makes them feel safe. I explain that they must take an inside-out approach towards the code of conduct: they can take the code of conduct out into the real world by applying it in their interactions with others and feel good about themselves for treating people in an exceptional way.	**Brainstorming** *In future, I would include this as a stimulus for an improvised movement exercise*

	By looking at the check in sessions, it is clear that self-esteem will vary slightly from day to day due to whatever happens during the day. 2. Warm up: I add a little aerobic “boogie” exercise to the warm up – not only to challenge them one last time, but to get them into a celebratory mood. 3. 5 minute recap: Participants notice how each session built on the previous ones and mention that by summarizing the programme they can realize how much they have mastered	*In a purely therapeutic setting where one can extend the length of the session, I would love to teach them a line dance as a fun last warm-up exercise on a song such as “I feel better when I’m dancing”* *In future I would include photo’s from the sessions*

	and how they overcame the uncertainty and nervousness they had at the commencement of the programme. I acknowledge their comments by highlighting how much strength and courage it took to overcome those fears and master each instruction presented to them.	*along with words such as strength and courage as a wall mural (art exhibition style) to affirm personal progress*
	4. Stimulus and improvised movement: Participants love the poem and state how it reiterates everything they think and feel when going out into society. The individual movement sequences that transpire from each stanza speak of personal revelation: sweeping, releasing, big and open movements – not to mention original.	*Possibly indicative of improved self-esteem*
	5. Stimulus and structured movement: When put together, I stood in awe of the movement piece which the six participants' improvised movements compiled. It was expressive enough to convey their message without using words, but also performance worthy. I could see that they were really proud of what they had created. Reading the poem while they executed the movement piece was a truly goose-bump moment and as they repeated it and gained confidence in what they were doing, their movements became even stronger and more defined.	*Possibly indicative of increased psychosocial wellbeing*

	They asked to do it to music, but as their movement was based on the rhythm of a poem, they struggled to make the counts work. I could see frustration was building up, so I intervened and explained that they are more than capable of doing the piece to the music, but adapting the moves and counts to fit the music and then synchronizing the movements is something that does not happens in 15 minutes, which was the time allocated for this section of the session. I explained that this is where the difference between movement and performance comes in: movement is expressive and spontaneous while performance takes hours and hours, weeks and even months of practice. So I suggested that we play the music in the background, while I read the poem and they execute the movement sequence. This ensured that the participants still ended off the session with an experience of success. 6. Termination of the programme: Participants want to know why I choose the words I wrote on each of their respective certificates. I referred to the instances when I noticed the specific characteristics that each participant showed.	*In future, I would clarify the difference between movement and performance art from the beginning* *This made me think how many false compliments they might have heard before, that they need to know that what I observed was*

	Each participant then asked if they could say what they would write on my certificate. The free movement session was very liberating for each participant. *Pantsula* movements were especially prominent.	*real and not just sugar coating* *Their words left me humbled and made me realise that even as an adult, we need to hear words of affirmation and appreciation* *Normative African dance movements such as Pantsula never featured during the other sessions, which makes me wonder about its expressive potential which*

	The participants also included me as the facilitator into their free movement session. 7. The reading of “Invictus” Whereas the participants were always chatting up a storm during sessions, a revered silence fell over the group as they listened to the poem “Invictus”. They’re response was: “That is deep”. They wanted to know if they could have a copy of this poem as well, so I ran to the copying machine to make copies to give to them.	*can still be unearthed* *This highlighted the very unique role that a Dance/Movement Therapist plays in the therapeutic process* *In future I will ensure that each client has a copy of this poem and perhaps add explanatory / interpretive notes on the back as some of the vocabulary is also not used in everyday spoken*

	8. Ending the session: After executing the curtsey and vocalising the meaning thereof, the group spontaneously gathered for a group hug.	*language* *Speaks of group cohesion and possible improvement in psychosocial wellbeing*
Any relation to literature studied? (Incl. references for easy referral) **and / or** **Suggestions about further reading…**	○ How the macro system is not informed about or prepared for persons with visual impairment ○ The connection between psychological and social aspects of psychosocial wellbeing and how self-esteem plays a determinant role in psychosocial wellbeing ○ How experiencing success contributes to self-esteem and subsequent psychosocial wellbeing ○ The difference between movement and performance art ○ Read more about the unique role of a Dance/Movement Therapist ○ Research the background of African dances such as Pantsula and the symbolism or meaning behind the dances to learn more about the expressive potential these dances hold	

	○ Read more about the interpretation or meaning of the poem “Invictus”	
Ideas to follow up on and / or Questions to explore further…	Choreograph a line dance which targets all the necessary muscles but also include empowering and self-affirming movements	
Personal views and opinions	I stood amazed at the progress the participants exhibited during this final session, but I could see that they feel this way inside the accepting and secure space of the group and were still not sure about whether they will be able to handle the outside world’s uninformed and unprepared thoughts, behaviour and infrastructure. The increase in self-esteem and subsequent psychosocial wellbeing which is hoped for will be a sweet victory, but I realize there is so much more to be done in terms of family and community education and transformation. Therefore I think that this programme holds so much more potential for expansion and elaboration – not only to include more personal preparation and skill equipment to handle the outside world for the participants/clients but to involve their micro and macro systems as well.	
Problem analysis **What was useful (good) / not useful (bad)?**	**Use:** ○ The adapted poem “I love being me” as a stimulus ○ The improvised and structured movement sequences ○ The “Best You” certificates ○ The freestyle movement session	**Disregard:** ○ Attempting to execute the structured movement piece to music

	○ The reading of “Invictus”		
Any other relevant information	Participants also asked if I could include a list of the self-affirming songs which we used during the intervention programme in their personal DMT Journey Journals		

Addendum U: Summary of participant reflections in their DMT Journey Journals

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 2 DATE: 21 August 2018 THEME: Create Connection & Cohesion

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Nervous	Stressed	Nervous	Nervous	Nervous	Good
First time	Enjoy spending time with peers	Don't know what lies ahead	Not use to sharing my feelings	Not sure about how it will feel when I am dancing	It was a good day
I can be kinder	Challenging to create own movement	Positive: Dancing and being with people I love	Positive: Combining movements and dancing together	Positive: Learning new things	Challenging: to get my body to do the movements
I can be calmer	My peers	I must trust more	I can do things if	I discovered I	Still feel the

	encouraged me	and be more open	I am more confident	have a bit of confidence	same (Good)
Difficult to look in the mirror	I feel better being with people I trust	Challenge: worrying what I will look like when doing my movement	Challenge: Creating own moves and doing it in front of others	Challenge: Thinking of movements to perform	
I need more confidence	Feel better than at the beginning	My peers smiled and waited patiently until I felt ready to move	Worried about whether other group members will accept me	They gave me high fives	
I feel relieved		It felt good motivating my peers	Others did not laugh and were positive about my movement	I participated to show others they can do the same	
		Happy	I am becoming more confident	I can have more confidence	
			Good, excited, want to be more open	Better	

Nervous; Uncertain; Most positive: dancing with peers; Most challenging: Improvising movement; Need more confidence; Need to trust more and be more open; Encouragement from others; Feel valued if they can support and motivate their peers; Feel better at the end of the session

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 3 **DATE: 23 August 2018** **THEME: Words Shape Me**

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Okay	Okay	Broken	Good	Bad	Good
Emotional	I enjoy creating new movements	Betrayed by best friend; cannot trust anyone	Can't wait to see what we are going to do	Other members are sad	I laughed a lot today
Positive: Moving	I discovered I am very creative	Positive: sharing my true feelings with my peers	Positive: Combining movements	I discovered I do have strengths	Positive: Doing movements with my friends

Hurtful words	My peers were with me every step of the way	I discovered I am loved by everyone around me	I discovered can do it if I believe in myself	They helped me when I fell	When a group member farted
Challenge: getting my feelings out	My strength lies in dancing	Challenge: Writing something that hurt me	Challenge: Showing movement to others	I helped them with spelling and it felt good	I discovered I have a bit more confidence and I should believe in myself more and I should love my body
Challenge: letting go	Feel better than before	They called me dance queen and loved my movements	I was worried about my body but they did not laugh, were not mean and accepted me	I am able to do the movements of others	Challenge: drawing pictures and dancing and giving advice to others
Positive words from my peers		It felt good helping others and giving them advice	I laughed with everyone	Happy	The others are very good at movement and make me look not so good
I feel better when		My strength is	My strength was		They told me I

I make others feel better		dancing	that I was open about the most hurtful thing I ever heard		look beautiful and I should believe in myself
Feel better		I can be more open with my peers	I can be more open and confident		I showed them love
		Fantastic and happy	Better		Giving love to others and sharing my feelings are my strengths
					Happy and loved

Check in feelings range from “Good”, “Okay” to “Broken and bad”; Due to events during the school day; Most positive: collaborative movement and being able to share thoughts and feelings; Main discovery: they have more confidence than they realized and they should believe in themselves more and that they are loved; Also discover strengths such as creativity, dancing/moving, sharing feelings and supporting others; Biggest challenge: Sharing hurtful words with other group members (in writing and through movement); Emphasis again on receiving encouragement from others and feeling that they can contribute by helping or supporting other group members; Body issues; Feelings at the end of the session range from feeling better to feeling happy, loved and fantastic

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 4 **DATE: 28 August 2018** **THEME: Feeling Feelings**

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Sick	Happy	ABSENT	Good	Bad	Angry
Flu	Positive: to learn new movements from each other		It was my birthday yesterday; I got chocolates from someone I thought did not know I existed	I am very hurt by a friend	I had a bad day
Positive: Helping other group members	I discovered I can work well with others		Positive: Working together as a group	Positive: Being able to let go of the bad things that happened today	I don't feel positive in this group because I am the youngest

Challenge: Move on from negative feelings to positive feelings through movement	I feel supported because my peers consider my feelings		Negative: Seeing another group member feel blue	Negative: Not everyone was participating	They told me to be strong and push myself to participate
I discovered I can do things	Happy		Challenge: Showing moves to other members	I have the ability to grow from bad to good	I supported and encouraged them
I have the strength to do it			I still don't accept myself	People's offensive words keep me from feeling better about myself	I feel worse
Other group members helped me			My group members did not judge me. They helped me	They helped me decide on some moves	
Better			It felt good to be able to help them	I made them laugh	
			Still good	I succeeded in feeling better	

				I want to get better at moving	
				I feel a bit better	

Check in feelings range from happy and good to sick, bad and angry; Due to significant events such as a birthday to hurtful comments from a friend; Most positive: collaborative movement and letting go of negative feelings from the day; Most challenging: sharing feelings through movement; feeling accepted and making each other feel included; Again refers to significance of support from peers and being able to support them in return; Most significant discovery: Ability; Importance of experiencing personal success and challenging oneself; Main reason why participants do not feel better about themselves: still looking for self-acceptance and they still keep on being confronted by others' hurtful words and opinions; Feelings at the end of the session range from happy, good, feeling better to feeling worse.

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 5 **DATE: 30 August 2018** **THEME: Rolling with Role Models**

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Excited	ABSENT	ABSENT	Good	ABSENT	Bad and good at the same time
I can fix things that go wrong in my life			I did very good in my Maths test		I cried in class but I felt better after crying
Positive: Hearing what my sisters think I am capable of			Positive: Learning about successful woman who also have low vision		Positive: I liked being in a smaller group
					Challenge: understanding what I read
I don't believe in myself enough			Challenge: not having all group		I discovered that I should be

			members there		myself and follow my passions even if I can't see well
I can do things I thought I couldn't			I have some of the same qualities as those role models		I felt like a butterfly flying in the air
They helped me feel better about myself			They told me I can be great lawyer cause I am smart and I am also good at writing poems and stories		I need to feel better about myself
Help others feel better about themselves			It felt good telling my peers what they are good at through movement		They encouraged me to be myself and do what I love
Happy			I was brave and showed everyone their good		I encouraged them to follow their dreams

			qualities. Usually I just keep quiet and to myself		even if they have eye problems
			Better		I feel loved and supported

Check in feelings range from excited and good to tired and bad; Those feeling better than others had experienced success during the day; Most positive: learning that there are successful individuals who have transcended their diagnoses of low vision to achieve success in various areas of the career world; They also liked being in a smaller group and hearing what they are capable of; Most significant discovery: that they already poses some of the same qualities as the mentioned role models; Another discovery was that they should believe more in themselves, their dreams and their capabilities; Biggest challenge: Creating improvised and structured movements; Again mention the relevance of having support and acceptance from group members and how good it feels to play a meaningful role in each others' journeys. Feelings at the end of the session are all on a positive scale, ranging from feeling happy, loved and supported and better than at the commencement of the session.

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 6 **DATE: 4 September 2018** **THEME: Personal Progress Patterns**

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Sad	Feel fine	Bad, sad, lonely, depressed	Good	Bad	Sick
Someone said hurtful things about me	Positive: my peers make me feel better and happier than at the beginning of the session	Saw something that hurt me	I was not rejected but accepted by a wonderful person	I was accused of something I didn't do	Flu
It feels good to cheer others up	I discovered that I am good at movement	Positive: Laughing with my peers and forgetting about what happened	Positive: creating our own choreography	I can work out choreography	I can be proud of myself for overcoming my weaknesses

Others help to build myself up	Challenging to create my first choreography piece	I discovered I can be confident even when something bad is going on	I can believe in myself	I can do things that seem difficult	The choreography part was a bit challenging for me
I must not keep my feelings in	My peers complimented me	Challenge: To be happy in front of my peers	Challenge: picking a song	Encouraging me to go to the front and show my choreography	Feeling bad about myself
Happy	It felt good to give others advice	My peers cheered me up and danced with me	They did not judge me	Reacting positively to their choreography	They encouraged and supported me
	My strength is dancing and helping others	I helped my peers to open up more	I enjoyed watching others choreography	I am getting to know myself better	I smiled at them to show support
	Happy	I can also be more open with others	I can be more open and brave	I feel better	I learnt I have strengths
		Better than before	Better than before		Still sick but better on the inside

Check in feelings range from fine and good to sad, bad and sick; Those who experience negative emotions were all subjected to negative feedback of some sort; Most positive: forgetting what happened and feeling better; Most significant discovery: various capabilities; Most significant challenge: first choreography; to transcend current negative feelings and to pick a song for the structured movement piece; Again refer to the pertinent role that their group members play in cheering and building them up and how good it feels to support and encourage their fellow group members; Most significant aspects keeping them from feeling better about themselves are: keeping feelings hidden, not opening up to others and not loving themselves enough.

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 7 **DATE: 6 September 2018** **THEME: Holding back or Helping**

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Okay	Tired	ABSENT	Okay	Good	Good and angry
Feel happier with myself	Long day		Someone was telling me mean things and I am trying to ignore it and its working sort off	I learnt I can do everything for myself even if I have bad vision	Someone made me angry at school but I ignored them
I mustn't overthink things	Positive: Supporting my group members		Positive: Learning the difference between helping and supporting	Positive: I discovered I can say a lot through movement	I must not hold back and I must move on
I don't want	I discovered		I don't like being	What people are	Challenge: it was

others to do everything for me I just want them to support me	there must be a balance between being independent and having support		so physically close to others; I need my personal space It's hard to do what you want if others are holding you back	saying about me keeps me from feeling better about myself	hard to move when the others were holding me back
It feels good to be there for others	My group members helped me and made me feel better		It does not help that others do everything for me, I need freedom to do things on my own and learn from my mistakes and succeed on my own	They made me turn faster and did not let me fall	I must push myself harder and never forget who I am and I must stay myself
Challenge: letting go of things	I was there for other group members		I feel safe to try things on my own if I know others are there	I supported their movements	They supported my movement so I could feel like I was flying

Happy	Dancing and helping others makes me feel more capable and stronger		I felt worth something because I could support my group members	My strengths is I can do things on my own but I feel safer when I know someone is there for me	I was there for them
	Happy		Better	Good	Loved and safe

Check in feelings range from good and okay to tired and angry; Positive feelings linked to feeling better about themselves and feeling capable while negative feelings are due to negative feedback or hurtful words from others outside of the group; Most positive: Learning the difference between taking away autonomy and independence and being there and providing support and learning to what extent and how well they can express themselves through movement; Most significant discovery: Learning that there must be a balance between independent behaviour, receiving guidance and/or support in order to achieve success; Reason why they are not feeling better about themselves: they overthink things, they hold back and do not move on and people from outside of the group continue to say hurtful things to them; Most significant challenge: trying to do what you want and trying to do it well, while others are limiting your movement and thus holding you back; Mention how they felt more free and yet more in control and safe at the same time knowing their group members are not directing their movements but rather supporting it; Also state how empowered they feel to know that their group members need and value their support; Feelings at the end of the session all range on a positive scale from happy , loved and safe to good and feeling better than before

DANCE / MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 8 **DATE: 11 September 2018** **THEME: From Small to Tall**

UNCERTAIN/BAD FEELINGS	NEGATIVE	CHALLENGES
CONFIDENT/GOOD FEELINGS	SUPPORT FROM OTHERS	SELF-DISCOVERY
POSTIVE	GIVING SUPPORT	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Okay	ABSENT	ABSENT	Bad	Good	Okay
Difficult day			Wrote two tests, bought a present for someone's birthday but they did not come to school	I have let go of my grudges	My day was just normal
Movement and dancing is positive			Positive: Learning to use space and levels and pasting and cutting	Positive is that I feel I know myself better now	I must give myself space. I must not be afraid of it
Get my feelings			Not all group	I can do what I	People thinking I

out through movement			members were there	want to despite my disability	can't do anything because I can't see well
Challenging to figure out my feelings			Challenge was being open about my journey so far	Realising the movements in my head	Creating movement for all the words I chose
Letting go instead of holding back			They did not judge my movement or my journey	Showing me the way	They encouraged me and supported me and showed me love so I knew they were there but I was doing it on my own
Feel more confident			I felt needed when I helped others to cut and paste after I was done	I encouraged them to be strong	I showed them I am there
Happy			I can be more open	My strength is participating	Better
			Better	Good	

Check in feelings range from Good to okay to bad; Due to challenges and/or success experienced during the day; Most positive: developing quality and range of movement to expand expressive repertoire, being creative and learning more about themselves; Negative aspects included that not all participants were present and that it was hard to get deep hidden feelings out through movement; Most significant challenges were figuring out and sharing feelings as well as creating movements to enable them to convey the identified feelings; Main reasons for not feeling better about themselves include society being misinformed about people with low vision and their actual capabilities, not holding back and letting go as well as being more open about their thoughts and feelings; They again reiterate the significant contribution their peers' support, encouragement and acceptance plays in feeling better about themselves and how nice it felt to be needed for once; Feelings at the end of the session are all on the positive scale ranging from confident, happy and good to feeling better than at the beginning of the session

DANCE / MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

SUMMARY OF PARTICIPANT REFLECTIONS

SESSION: 9 **DATE: 13 September** **THEME: Salute to Self-Worth**

UNCERTAIN/BAD FEELINGS	**NEGATIVE**	**CHALLENGES**
CONFIDENT/GOOD FEELINGS	**SUPPORT FROM OTHERS**	**SELF-DISCOVERY**
POSTIVE	**GIVING SUPPORT**	

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C	PARTICIPANT D	PARTICIPANT E	PARTICIPANT F
Good	**Okay**	**Good**	**Good**	**Very full**	**Good**
It's my birthday	**I enjoyed myself**	**I passed my**	**Feel positive**	**I ate a lot**	**I had a wonderful**

		maths test	about tests I wrote		day
Encouragement makes me feel more able	I discovered I can dance a long sequence of movement	Positive: dancing together	Positive: Joining our movements	This session was lots of fun, I liked the poem and dancing together	I have reason to love myself
Encouraging others makes me feel good	Happy	I discovered we are good at putting together a dance together and we are all good dancers	I enjoy and am good at other things than just writing poems and stories	I am good at moving	They smiled at me and cheered for me
Happy		Dancing and being there for others is my strength	Remembering all the moves	They showed me the right way of doing their moves	I did the same
		Happy and excited	They did not judge my movement or the way I did theirs	I was there to support and cheer for them	Good
			I joined them when they were dancing in a	I feel better about being myself	

			circle		
			I am brave	**Happy**	
			Better and excited		

Check in feelings range from good to okay; Due to significant events such as a birthday and experiencing success; Most positive: collaborative movement; Most significant challenge: remembering a longer movement sequence; Most significant discoveries: abilities as individuals and as a group, reasons for self-worth and potential; Again refer to how encouragement from group members has enabled them to execute their movement sequences and that they feel appreciated when they are able to do the same for the other members of the group; Feelings at the end of the session and at the termination of the intervention programme feeling better, feeling good, feeling happy to being excited

Addendum V: Coding process

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 2 **DATE: 21 August 2018** **THEME: Create Connection & Cohesion**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	sinking; enclosing; retreating; shrinking; shortening and narrowing	○ Uncertainty
	Quality of movement	quickly executed; movements executed quickly; limp	
	Effort of movement	bounded; limp; heavy	
	Limited range of movement	small; not fully executed; bounded; executed close to the body; small and uncertain; only engage the upper body; prefer arm movements	
	Use of space	no use of space; use of immediate space; Very aware of the space around them	
	Movement patterns	rocking; hugging; punches	
	Movement preferences	hands; arms	
	Range and quality of movement increases for some participants as session progresses	Spreading; advancing; lengthening and widening	○ More familiar ○ More certain ○ Gain confidence
	Some participants' effort of movement improves as session progresses	free; light; strong; sustained	
	Some participants used their immediate	horizontal; vertical; cross-lateral	

	space as session progressed		
	Change in movement patterns and preferences as session progresses	circling arms, hip movements	
	Group	Movements become more definite when dancing as a group; Movements executed quickly to be able to return to the safety of the group; More self-confidence when executing movements as a group	○ Security of the group
	Facial expressions and body language (other observations)	look down a lot; giggled; look around, fidget with hands or clothing; look at facilitator and other group members for affirmation; shrug	○ Insecurity
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	nervous; stressed; first time dancing; not used to sharing feelings; don't know what lies ahead	○ Fear of the unknown
	Most positive aspect about the session	doing the movement sequence with peers	○ Security of the group
	Most challenging part of the session	thinking of and doing own movement sequences; looking in the mirror; getting my body to do the movements; worried about what I will look like	○ Fear of the unknown ○ Insecurity ○ Low self-esteem ○ Physical aspect of self-esteem
	Needs	need more confidence; to feel better about myself;	○ Insecurity ○ Afraid to trust ○ Low self-esteem

		need to trust more; be more open	○ Psychological aspect of self-esteem
	Peer contributions	encouraged me; gave me high fives; waited patiently until I was ready; they did not laugh and were positive about my move	○ Value encouragement from others ○ Accepting and ability-promoting environment ○ Social aspect of self-esteem ○ Improving self-esteem
	Participant contribution	felt good motivating my peers; I participated to show others they can do the same	○ Feel valued because they can support group members ○ Social aspect of self-esteem
	End of the session	relieved; better; happy; excited; good	○ More familiar ○ More certain
Process notes in researcher's diary	Participants seem unsure and nervous	look around; giggle; fidget with hands or clothing; ask many questions; very formal; look at facilitator and other group members for affirmation	○ Uncertainty ○ Fear of the unknown ○ Insecurity
	Movement	no one wants to go first; small movements that are	○ Uncertainty ○ Fear of the unknown

		not fully executed; executed close to the body; movements executed quickly; very aware of the space around them; stronger and more defined movements with each repetition of the movement sequence; more self-confidence when executing movements as a group	○ Insecurity ○ More familiar ○ More certain ○ Gain confidence ○ Security of the group ○ Social aspect of self-esteem
	Code of conduct	centered around protecting themselves emotionally; may not judge each other; always act and speak with kindness; must not break each other down; may not laugh at each other; will not act like are better than others; respect each other; don't be a bully	○ Low self-esteem ○ Scared of self-esteem being broken down further ○ Psychological aspect of self-esteem ○ Social aspect of self-esteem
	Group name	feeling all kinds of feelings; are all different; no one knows how bright we can really shine until a person gets close enough to know us; we feel like our	○ Low self-esteem ○ Psychological aspect of self-esteem ○ Social aspect of self-esteem

		brightness is far away…out of reach; if we could get the chance and have the courage to shine, we will be brilliant; feel understood; sense of camaraderie	
	Mirror	no one wants to look in the mirror; cover faces with hands; walk away to look into mirror alone	○ Low self-esteem ○ Physical aspect of self-esteem

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 3 **DATE: 23 August 2018** **THEME: Words Shape Me**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	narrow; enclosed; shortened; sinking; arms spreading, lengthening and widening slightly above head	○ Uncertainty ○ More familiar
	Quality of movement	still executed sudden and quick	
	Effort of movement	quality of movement has developed from being limp to being	○ More certain

		light; more free than bounded, but still limited	
	Limited range of movement	still small and uncertain; still limited to upper body; slight; movements slightly increasing in range of movement	○ Gain confidence
	Use of space	still avoid using the space or only extend into immediate space; slight arm movements away from body centre; small advancing steps arm movements have slightly expanded to include small vertical and/or horizontal movements; a few cross-lateral movements	○ More familiar ○ More certain ○ Gain confidence ○ Gain confidence
	Movement patterns	releasing and opening patterns of movement	○ Change in pattern ○ Feeling more capable
	Movement preferences	preferences are expanding to arm-, leg- and hip movements	○ Improving self-esteem
	Group	Movements are stronger when dancing as a group	○ Security of the group
	Facial expressions and body language (other observations)	Still look down a lot; hide face behind hands; still lots of giggling; some smiles	○ Insecurity ○ More relaxed
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	okay; broken; bad; good; feeling emotional; betrayed by best friend; other members are sad; can't wait to see what	○ More familiar ○ Influence of daily events on self-esteem ○ Social aspect of self-esteem

		we do today; I laughed a lot today	
	Most positive aspect about the session	collaborative movement; sharing thoughts and feelings	○ Important role of the group
	Most challenging part of the session	dealing with and sharing hurtful words with other group members (in writing and through movement); letting go; doing the movements; worried about my body	○ Fear of being judged ○ Insecurity ○ Social aspect of self-esteem ○ Physical aspects of self-esteem ○ Process of transcending
	Self-discovery	have more confidence than they realized; should believe in themselves more; they are loved	○ Insecurity ○ Afraid to trust ○ Low self-esteem ○ Psychological aspect of self-esteem
	Peer contributions	positive words from my peers; my peers were with me every step of the way; they called me the dancing queen and loved my movements; they did not laugh, were not mean and accepted me; they told me I look beautiful and should believe in	○ Value encouragement from others ○ Positive interactions ○ Important role of the group ○ Accepting and ability-promoting environment ○ Social aspect of self-esteem

		myself	○ Improving self-esteem
	Participant contribution	I feel better when I make others feel better; it felt good helping others and giving them advice; I helped them with spelling and it felt good	○ Feel valued because they can support group members ○ Positive interactions ○ Social aspect of self-esteem ○ Improving self-esteem
	End of the session	better; fantastic; happy; loved;	○ More familiar ○ More certain ○ Improving self-esteem
Process notes in researcher's diary	Participants want to know whether they did their reflections right.	fear of failure; need for approval	○ Uncertainty ○ Low self-esteem
	Participants want to know whether the code of conduct is going to remain on the wall where they decided to display it.	need for reassurance	○ Insecurity ○ Low self-esteem
	Participants formed Whatsapp group with group name and designed four possible profile pictures / logos that display group name	group cohesion	○ Positive interactions

	"Starlight Mix"		
	Movement	movements expressing feelings about negative feedback are generally small and executed close to the body; movements expressing feelings about positive feedback are more open and definite; in general movements are more controlled movements are most defined and extended during the group movement sequence	○ Insecurity ○ Low self-esteem ○ Improvement in self-esteem ○ Security of the group ○ Social aspect of self-esteem
	Other observations	Try to hide negative feedback that they write down on paper; surprised when reading positive feedback; less looking around; more willing to share movement expressions; continue more independently with reflection; curtsey more coordinated and definite executed for the second time; growing group	○ Insecurity ○ Low self-esteem ○ More familiar ○ More certain ○ More capable ○ Positive

		cohesion and mutual trust; more comfortable with and trusting towards each other; knowing that they are each other's witnesses and supporters seems to boost self-confidence	interactions ○ Important role of the group ○ Feel valued because they can support group members ○ Social aspect of self-esteem

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 4 **DATE: 28 August 2018** **THEME: Feeling Feelings**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	improvised movement sequences: sinking; enclosing; retreating;	○ Uncertain and unplanned nature of improvisation ○ Insecurity ○ Less uncertain and unknown ○ More planned in nature ○ Experience success
	Quality of movement	improvised movements: executed quickly structured movement sequences: reflect sustained movement	
	Effort of movement	improvised movement sequences: bounded; limp more free than bounded quality of movement although limited to arm movements and characteristic of structured movement	

	Limited range of movement	improvised movement sequences marked by limited range of movement; participant who felt excluded based on age – displayed small, hunched movements increased range of movement when doing structured movement	○ Insecurity ○ More planned ○ Experience success
	Use of space	all participants show increased use of space - vertically and/or horizontally	○ More familiar ○ Experience success
	Movement patterns	wrapping arms around self; spreading or opening arms	○ Change in pattern ○ Letting go ○ Process of transcendence
	Movement preferences	Preferences now include not only arm movements, but turns and runs as well	○ Feeling more capable ○ Experience success ○ Gain confidence
	Facial expressions and body language (other observations)	Biting lip; pouting; smiling	○ More relaxed ○ Gain confidence
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	sick; happy; bad; angry; good; I have the flu; it was my birthday yesterday; I am hurt by a friend; I had a bad day	○ Influence of daily events on self-esteem ○ Social aspect of self-esteem ○ Physical aspect of self-esteem
	Most positive aspect about the session	collaborative movement; letting go	○ Important role of the group ○ Process of transcendence
	Most challenging part of the session	moving on from negative feelings to positive feelings	○ Process of transcendence ○ Influence from

		through movement; don't feel accepted; people's offensive words keep me from feeling better about myself; I still don't accept myself	○ wider social systems ○ Social aspect of self-esteem ○ Low self-esteem ○ Psychological aspect of self-esteem
	Self-discovery	I can do things; I have the strength to do this; I can work well with others; I have the ability to grow from bad to good; I succeeded in feeling better; I want my body to get better at moving	○ Process of transcendence ○ Psychological aspect of self-esteem ○ Physical aspect of self-esteem ○ Experience success ○ Improvement in self-esteem
	Peer contributions	other group members helped me; I feel supported because my peers consider my feelings; my group members did not judge me. They helped me; they helped me decide on some moves; they told me to be strong and push myself to participate	○ Value encouragement from others ○ Positive interactions ○ Important role of the group ○ Accepting and ability-promoting environment ○ Social aspect of self-esteem
	Participant contribution	It was positive helping other group members;	○ Feel valued because they can

		it felt good being able to help them; I made them laugh; I supported and encouraged them	support group members o Positive interactions o Social aspect of self-esteem o Improving self-esteem
	End of the session	better; happy; good; worse	o Improving self-esteem o Insecurity
Process notes in researcher's diary	Hand out journals and display of group name	Address need for sense of acceptance and security	o Uncertainty o Fear of the unknown o Insecurity
	Movement	familiar with the warm up exercises; continue challenging to keep on experiencing transcendence of what think can't do and experience success; movements representing feeling of failure are small, close to the body, contracted and hunched; movements representing feeling of success are more extended, elongated	o More familiar o More certain o Gain confidence o Experience success o Process of transcendence o Uncertainty o Fear of the unknown o Insecurity

		and open; intervening movements participants create for one another to move each other away from failure towards success symbolizes support and encouragement and encourages more open, grander and sweeping movement using space.	○ Feel valued because they can support group members ○ Positive interactions ○ Social aspect of self-esteem
	Additional notes	struggle to explain how feel or understand how others feel because can't always see other's facial expressions – makes them feel inadequate; being younger than other group members might make a participant feel less experienced and less competent; ability to express self better can build on a person's self-esteem; must be balance between effort you put in to achieve success and support and	○ Social aspect of self-esteem ○ Low self-esteem ○ Group compilation ○ Social aspect of self-esteem ○ Improvement in self-esteeml ○ Psychological

		encouragement you need to get to make the most of that effort; two facilitators may make facilitation of sessions more effective	aspect of self-esteem o Social aspect of self-esteem o Effective facilitation

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 5 **DATE: 30 August 2018** **THEME: Rolling with Role Models**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	improvised movement sequences: enclosing structured movement: lengthening; widening	o Uncertain and unplanned o Less uncertain and unknown
	Quality of movement	improvised movements: sudden and quick	
	Effort of movement	improvised movement sequences: bounded structured movement sequences: free; strong	o Unsure o o More planned in nature o Experience success
	Limited range of movement	improvised movement: small structured movement increases horizontally in range	o Uncertain o More familiar
	Use of space	improvised movement: decreased use of space structured movement: increased use of space; moving away	o Unsure o More planned o Experience success

		from the centre body and utilizing more space	
	Movement patterns	self soothing movements; closing eyes with hands to indicate that they can't see well; releasing and spreading arms	○ Insecure about eyesight ○ Change in pattern ○ Letting go ○ Process of transcendence
	Movement preferences	preferences now include not only arm and hip movements; turns	○ Feeling more capable ○ Gain confidence
	Facial expressions and body language (other observations)	frowning; smiling	○ More relaxed ○ Gain confidence
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	excited; good; bad; I can fix things that go wrong in my life; I did very good in my Maths test; I cried in class but I felt better after crying	○ Influence of daily events on self-esteem ○ Social aspect of self-esteem ○ Improving self-esteem
	Most positive aspect about the session	hearing what my sisters think I am capable of; learning about successful woman who also have low vision; I liked being in a smaller group	○ Important role of the group ○ Accepting environment ○ Influence of wider social system ○ Group compilation
	Most challenging part of the session	not having all group members there; understanding the reading content	○ Sign of established group cohesion ○ Social aspect of self-esteem ○ Language

			proficiency
	Self-discovery	I don't believe in myself enough; I can do things I thought I couldn't; I have some of the same qualities as those role models; I was brave and showed everyone their good qualities. Usually I just keep quiet and to myself; I discovered that I should be myself and follow my passions even if I can't see well; I need to feel better about myself	○ Low self-esteem ○ Psychological aspect of self-esteem ○ Experience success ○ Improvement in self-esteem
	Peer contributions	they helped me feel better about myself; they told me I can be great lawyer cause I am smart and I am also good at writing poems and stories; they encouraged me to be myself and do what I love	○ Value encouragement from others ○ Positive interactions ○ Important role of the group ○ Social aspect of self-esteem ○ Accepting and ability-promoting environment ○ Improving self-esteem
	Participant contribution	help others feel better about themselves; it	○ Feel valued because they can

		felt good telling my peers what they are good at through movement; I encouraged them to follow their dreams even if they have eye problems	support group members ○ Positive interactions ○ Social aspect of self-esteem ○ Improving self-esteem ○ Process of transcendence
	End of the session	happy; better; loved and supported	○ Improving self-esteem ○ Increased group cohesion
Process notes in researcher's diary	Start of the session	more at ease, spontaneous and willing to share; participant who felt inferior to other participants feels more accepted and at ease	○ More familiar ○ More certain ○ Gain confidence ○ Group compilation
	Movement	○ movements are starting to expand – moving away from the centre body and utilizing more space	○ More familiar ○ More certain ○ Gain confidence ○ Experience success
	Role models	did not know of other people with low vision that they can look up to; associated with	○ Social aspect of self-esteem ○ Low self-esteem ○ Important role of wider social

		Thando Hopa because she was from South Africa; other role models each participant associated with were based on a shared passion such as singing, writing or acting; lack of role models who have also been diagnosed with low vision has an effect on self-esteem and psychosocial wellbeing;	system ○ Low self-esteem ○ Psychological aspect of self-esteem ○ Social aspect of self-esteem
	Additional notes	eager and willing to share their movement they created for their fellow participant; chance to mean something to someone else and make a worthwhile and acknowledged contribution to someone else's life reflections are personal, detailed and in-depth due to smaller number of participants	○ Feel valued because they can support group members ○ Positive interactions ○ Social aspect of self-esteem ○ Improves self-esteem ○ Group compilation

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 6 **DATE: 4 September 2018** **THEME: Personal Progress Patterns**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	improvised movement: shrinking; sinking; enclosing structured movement: spreading; widening; rising; advancing	○ Uncertain and unplanned nature of improvisation ○ Less uncertain
	Quality of movement	improvised movements: sudden and quick structured movement sequences: slightly more sustained movement	○ Insecure ○ More planned in nature ○ More confidence
	Effort of movement	improvised movement sequences: bounded; limp (limited to two participants) structured and improvised movement of majority of participants: free; strong; light	○ Insecurity ○ Gaining confidence ○ Experience success ○ Improving self-esteem
	Range of movement	increase in range of movement when doing structured or improvised movement	○ Progression in movement ○ Improved self-esteem
	Use of space	all participants show increased use of space – vertically; horizontally; cross-lateral; sagital	○ Progression in movement ○ Improved self-esteem
	Movement patterns	releasing and opening, spreading or	○ Change in pattern ○ Letting go

		even throwing arms apart	○ Process of transcendence ○ Progression in movement ○ Improved self-esteem
	Movement preferences	arm-, leg- and hip movements as well as turns	○ Feeling more capable ○ Experience success ○ Gain confidence
	Facial expressions and body language (other observations)	smiling	○ More relaxed ○ Enjoyment ○ Gain confidence
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	Sad; fine; bad; lonely; good; sick; someone said hurtful things about me; I saw something that hurt me; I was accused of something I didn't do; I am sick with the flu	○ Influence of daily events on self-esteem ○ Influence of the wider social system ○ Social aspect of self-esteem ○ Physical aspect of self-esteem
	Most positive aspect about the session	my peers make me feel better and happier than at the beginning of the session; Laughing with my peers and forgetting about what happened; creating our own choreography	○ Important role of the group ○ Increasing group cohesion ○ Accepting environment ○ Feeling more capable ○ Experience success ○ Gain confidence
	Most challenging part	to create my first	○ Uncertain

	of the session	choreography piece; to be happy in front of my peers; the choreography part was a bit challenging for me	○ Insecure
	Self-discovery	I discovered that I am good at movement; I must not keep my feelings in; I discovered I can be confident even when something bad is going on; I can believe in myself; I can work out choreography; I can do things that seem difficult; I can be proud of myself for overcoming my weaknesses; my strength is dancing and helping others; I can also be more open with others; I can be more open and brave; I am getting to know myself better; I learnt I have strengths	○ Process of transcendence ○ Psychological aspect of self-esteem ○ Physical aspect of self-esteem ○ Experience success ○ Improvement in self-esteem
	Peer contributions	others help to build myself up; my peers complimented me; my	○ Value encouragement from others

		peers cheered me up and danced with me; they did not judge me; encouraging me to go to the front and show my choreography; they encouraged and supported me	○ Positive interactions ○ Important role of the group ○ Social aspect of self-esteem ○ Increased group cohesion ○ Accepting and ability-promoting environment ○ Improving self-esteem
	Participant contribution	it feels good to cheer others up; it felt good to give others advice; I helped my peers to open up more; reacting positively to their choreography; I smiled at them to show support	○ Feel valued because they can support group members ○ Positive interactions ○ Social aspect of self-esteem ○ Improving self-esteem
	End of the session	happy; better	○ Improving self-esteem
Process notes in researcher's diary	Recap of first half of the sessions of the programme	feels closer to the other group members; felt "torn" at the beginning of the intervention programme but she is starting to "heal"; learning how to "trust" the truth in other people's positive	○ Uncertainty ○ Fear of the unknown ○ Insecurity ○ Process of transcendence ○ Improving self-

		verbalisations and how to "let go" of persons' negative words; if this programme will continue for others learners after they have completed it they would want to assist to show others what to do; was very "scared" at the commencement of the intervention programme, but she is starting to "believe" in herself a bit more every day	esteem ○ Increasing group cohesion ○ Feel valued when they can support others
	Movement	challenge the participants; impressed with themselves after showing determination and finishing the exercise – some say that they didn't think they could make it; some participants' choreography is all indicated on one side in the top corner of the page; movements correlate with what created on paper: small, narrow movements staying more or less in one place; fear of space and the unknown;	○ Gain confidence ○ Experience success ○ Process of transcendence ○ Uncertainty ○ Fear of the unknown ○ Insecurity
	Additional notes	explain what choreography is; learnt about strengths and weaknesses in Personal and Social	○ Language proficiency ○ Link between Life Skills and DMT ○ Psychological

		Wellbeing (PSW) as part of the subject Life Skills; study Life Skills curriculum (PSW, PE and even Creative Arts) to see if the intervention programme might be incorporated in the curriculum; each session thus far not only refers to psychological development but progression in social development as well; confirming that self-esteem is not something that improves or proliferates in isolation; Social aspects from the micro and macro system definitely influence self-esteem and therefore psychosocial wellbeing	aspect of self-esteem o Social aspect of self-esteem o Role of wider social system

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 7 **DATE: 6 September 2018** **THEME: Holding back or Helping**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	improvised movement: shrinking, enclosing or narrowing due to the other participant restricting their movement structured movement: rising; advancing; lengthening; spreading; widening;	○ Restrained movement ○ Progression in movement ○ Improved self-esteem
	Quality of movement	majority of participants display sustained movement; stronger, more definite, open and fluent sustain movement for longer, turn faster and slide further with support from other group members	○ More control ○ Progression in movement Improved self-esteem ○ Increase in group cohesion ○ Important role of the group
	Effort of movement	stimulus of improvised movement implies bounded movement; structured movement: free; light; strong; light	○ Restrained movement ○ Supported movement
	Range of movement	stimulus of improvised movement implies bounded movement; increase in range of	○ Restrained movement

		structured movement; willing to try new and more daring movements with support from peers	○ Progression in movement ○ Increase in group cohesion
	Use of space	moving forwards and backwards through space; moved on vertical and/or horizontal plane; explore movements requiring core support along with vertical and horizontal movements	○ Gaining confidence ○ Experience success ○ Improving self-esteem
	Movement patterns	walking; rising; turning; effort of escaping restraints of other participants during the improvised movement; patterns turned into supported movements during the structured movement	○ Change in pattern ○ Process of transcendence ○ Acknowledging need for indepence ○ Acknowledge that still want support
	Movement preferences	preferences include leg movements, rising and turning; the usual arm movements only started to feature during the structured movement sequences; symbolizes that during the "holding back" improvised movement sequence, participants were kept from doing what they would like to do	○ Role of wider social systems ○ Need for independence
	Facial expressions and body language (other observations)	during improvised movement: frowning, looking frustrated,	○ Uncertainty ○ Insecurity

		angry, uncomfortable and uncertain; one member did not like others entering her personal space; during structured movement: smiling and laughing and looking more relaxed	○ Progression in movement ○ Gaining confidence ○ Experience success ○ Improving self-esteem
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	okay; tired; good; angry; feel happier with myself; long day; someone was telling me mean things and I am trying to ignore it and its working sort off; I learnt I can do everything for myself even if I have bad vision; someone made me angry at school but I ignored them	○ Influence of daily events on self-esteem ○ Influence of the wider social system ○ Social aspect of self-esteem ○ Physical aspect of self-esteem ○ Psychological aspect of self-esteem ○ Process of transcedence
	Most positive aspect about the session	supporting my group members; learning the difference between helping and supporting; I discovered I can say a lot through movement ; positive feelings linked to feeling better about	○ Feel valued because they can support group members ○ Positive interactions ○ Feeling more capable ○ Experience success ○ Gain confidence

		themselves and feeling capable	
	Most challenging part of the session	letting go of things; it was hard to move when the others were holding me back; negative feelings are due to negative feedback or hurtful words from others outside of the group	○ Process of transcendence ○ Uncertain ○ Insecure ○ Role of wider social system
	Self-discovery	I mustn't over-think things; I don't want others to do everything for me I just want them to support me; I discovered there must be a balance between being independent and having support; I don't like being so physically close to others; I need my personal space it's hard to do what you want if others are holding you back; it does not help that others do everything for me, I need freedom to do things on my own and learn from my mistakes and	○ Social aspect of self-esteem ○ Need for independence ○ Psychological aspect of self-esteem ○ Improvement in self-esteem ○ Process of transcendence

		succeed on my own; I must push myself harder and never forget who I am and I must stay myself; learning difference between taking away autonomy and promoting independence	
	Peer contributions	my group members helped me and made me feel better; I feel safe to try things on my own if I know others are there; they made me turn faster and did not let me fall; they supported my movement so I could feel like I was flying; felt more free and yet more in control and safe at the same time knowing their group members are not directing their movements but rather supporting it	○ Value encouragement from others ○ Positive interactions ○ Important role of the group ○ Social aspect of self-esteem ○ Increased group cohesion ○ Accepting and ability-promoting environment
	Participant contribution	it feels good to be there for others; I was there for other group members; I felt worth something because I	○ Feel valued because they can support group members ○ Positive

		could support my group members; I supported their movements; I was there for them	interactions ○ Accepting and ability-promoting environment ○ Social aspect of self-esteem ○ Improving self-esteem
	End of the session	happy; better; good; loved and safe	○ Improving self-esteem ○ Increased group cohesion ○ Accepting and ability-promoting environment
Process notes in researcher's diary	Outside DMT intervention programme	collaborated each participant's pattern movement sequence to choreograph their own movement piece	○ Established group cohesion
	Reflection before improvised movement	"They think you can't do anything for yourself"; "They think we are going to get hurt if they are not there like all the time"; "They want to do everything for us"; They say I won't be able to drive to work one day"	○ Uncertainty ○ Fear of the unknown ○ Insecurity ○ Role of wider social system ○ Keep from acting independently and experiencing success ○ Need for independence
	Reflection after	"Like being stuck"; "Like I am carrying	○ Uncertainty

	improvised movement	everyone else with me – it feels heavy, like I felt now when we were moving" "Frustrated, like I did now when we tried to move together"; "Like someone is holding on to me and I have to drag them with me – sort of like now when I had to move with my sisters holding on to me"	○ Fear of the unknown ○ Insecurity ○ Role of wider social system ○ Keep from acting independently and experiencing success ○ Need for independence
	Reflection after structured movement	"I felt more able to move this time. The previous time they were holding me back"; "If it makes sense: I had more freedom but also more control"; "I could do what I want, but I knew they were there"; "I felt like I could fly because I felt safe to try what I wanted to do"; "I could do more knowing that they were there if I needed them. My arms didn't get tired and I could lift my leg higher"; "I want to make my own mistakes; I want to learn, but I want to know people will be there for me if I ask"; We can do things on our own but we need encouragement and support"; "It's like when I am running the 1500m – I can do it on my own, but I feel I don't get tired so quickly if people are	○ Feeling more capable ○ Experience success ○ Gain confidence ○ Role of wider social system ○ Need for independence ○ Need support ○ Process of transcendence

		on the side cheering me on"; "I feel safer to take risks if I know there are others who support me in trying and who will pick me up if I fall"	
	Movement	experimenting with spontaneous movement; suggests growing confidence in moving without guidance and using it as a means of self-expression; trust has developed; but the extent differs for each participant as some executed more daring movements than others	○ Progression in movement ○ Gain confidence ○ Experience success ○ Improving self-esteem ○ Process of transcendence ○ Increasing group cohesion
	Additional notes	sharing more during the check in sessions; quite upset that one participant is absent again; concerned that she is not going to benefit as much from the programme as they are; more confidence; more willing to act independently; reflection happens naturally and independently; willing to share their reflections with the	○ Increasing group cohesion ○ Accepting and ability-promoting environment ○ Social aspect of self-esteem ○ Role of wider social system ○ Gain confidence ○ Experience success ○ Improving self-esteem ○ Psychological aspect of self-esteem

		group; family and or community members do everything for a person with low vision and keep them from making valuable contributions to the household or society and thus robbing them of experiencing success and having a sense of self-worth; consider the cultural and religious stigmas which are involved in South Africa's frame of reference; should be addressed through family and community psychology	

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 8 **DATE: 11 September 2018** **THEME: From Small to Tall**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	using variety of body shapes to illustrate different levels	○ Progression in movement ○ Improved self-esteem ○ More control
	Quality of movement	sustained; more control, extended and independent movement; orientated, focused and self-assured movement	○ Progression in movement ○ Improved self-esteem
	Effort of movement	free; light; strong	○ Progression in movement ○ Gaining confidence ○ Experience success
	Range of movement	wide range of movement	○ Improving self-esteem ○ Process of transcendence
	Use of space	vertical; horizontal; cross-lateral; sagital; core-support; ventured further into the space around them	○ Process of transcendence ○ Change in pattern ○ Gaining confidence ○ Feeling more capable
	Movement patterns	holding and releasing contracting and expanding; making a heart shape with hands	
	Movement preferences	sweeping arms movements and turns	

	Facial expressions and body language (other observations)	very emotional, expressive and interpretive of movements that are being executed; joy, relief, smiling and determination; more expressive with softer and harder accents	
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	okay, bad; good; difficult day; wrote two tests, bought a present for someone's birthday but they did not come to school; I have let go of my grudges; my day was just normal;	○ Influence of daily events on self-esteem ○ Influence of the wider social system ○ Social aspect of self-esteem ○ Process of transcedence
	Most positive aspect about the session	movement and dancing; get my feelings out through movement; learning to use space and levels and pasting and cutting; I feel I know myself better now;	○ Feeling more capable ○ Experience success ○ Gain confidence ○ Physical aspect of self-esteem ○ Psychological aspect of self-esteem ○ Process of transcedence
	Most challenging part of the session	to figure out my feelings; letting go instead of holding back; being open about my journey so far; realising the movements in my head; people thinking	○ Process of transcendence ○ Uncertain ○ Insecure ○ Role of wider social system

		I can't do anything because I can't see well; creating movement for all the words I chose	
	Self-discovery	I must give myself space. I must not be afraid of it; I can be more open; my strength is participating; I can do what I want to despite my disability	○ Improvement in self-esteem ○ Social aspect of self-esteem ○ Psychological aspect of self-esteem ○ Process of transcendence
	Peer contributions	they did not judge my movement or my journey; showing me the way; they encouraged me and supported me and showed me love so I knew they were there but I was doing it on my own	○ Value encouragement from others ○ Positive interactions ○ Important role of the group ○ Social aspect of self-esteem ○ Increased group cohesion ○ Accepting and ability-promoting environment
	Participant contribution	I felt needed when I helped others to cut and paste after I was done; I encouraged them to be strong; I showed them I am	○ Feel valued because they can support group members ○ Positive interactions

		there	○ Accepting and ability-promoting environment ○ Social aspect of self-esteem ○ Improving self-esteem
	End of the session	happy; better; good	○ Improving self-esteem
Process notes in researcher's diary	Outside DMT intervention programme	started doing the cool down stretches and breathing exercises at night before bath time to cope with academic stress	○ Established group cohesion ○ Gained confidence ○ Experience success
	Movement	movements which they create do not only speak of understanding but also of originality; movements are more expanded, elongated and open; use more space and vary the level of their movements more than before; some participants are more comfortable with using space and levels than others; could also have to do with the range of movement with which their bodies feel comfortable; those who I have observed to be more supple when doing warm-up and cool down exercises do seem more comfortable with	○ Progression in movement ○ Gain confidence ○ Experience success ○ Improving self-esteem ○ Uncertainty ○ Physical aspect of self-esteem

		spreading out in to space, enlarging their movements and moving between lower and higher levels; structured movement sequences speak of a release; of liberation	○ Process of transcendence
	Additional notes	Participants found the idea of removing the "dis-" from "disability" very significant; want to keep the structured movement piece which they have created on paper because it reminds them of how far they have come and how much they have grown.; need for validation, possible fear of regressing back to previous level of self-esteem when leaving the programme; explain higher order words; the importance of observing every participant individually during every session from start to finish; physical ability and personal progress had to be considered	○ Process of transcendence ○ Psychological aspect of self-esteem ○ Uncertainty ○ Insecurity ○ Role of wider social system ○ Language proficiency ○ Progression in movement ○ Gain confidence ○ Experience success ○ Improving self-

		when evaluating the structured movement sequence; all participants have made progress in trusting the space around them	esteem

DANCE/MOVEMENT THERAPY INTERVENTION PROGRAMME FOR ADOLESCENT GIRLS WITH LOW VISION

CODING OF QUALITATIVE DATA

SESSION: 9 **DATE: 13 September** **THEME: Salute to Self-Worth**

DATA COLLECTION PROCEDURE	DATA EXCERPT, WORD OR PHRASE	COLOUR CODED WORDS OR PHRASES	RECURRING AND INTERSECTING CODES
Observation schedules	Shape of movement	improvised and structured movement sequences reflect an array of body contours and movement designs to express thoughts and emotions	○ Progression in movement
	Quality of movement	sustained; movements are defined and determined; movements are deliberate and even daring; movements are creative and original; execution is spontaneous but yet confident and convincing	○ Gained confidence
	Effort of movement	free; light; strong; extended and graceful	○ More control
	Range of movement	improvised as well as structured movements amplified in range; progressively develop into transcendent elaborate movements; 2 participants used full range of movement	○ Experience success

	Use of space	All the participants' movements have expanded from purely vertical and horizontal movements to include cross-lateral and sagittal movements as well; No one executed half body movements limited to only the upper or lower body anymore	○ Familiar ○ Gained confidence ○ Experienced success
	Movement patterns	holding and releasing; contracting and expanding; forward walks; narrowing; lengthening and shortening; forming heart shape with hands; rising and sinking; spreading and enclosing;	○ Pattern has changed throughout ○ Process of transcendence
	Movement preferences	finger-, hand- , sweeping arm-, leg- and hip movements as well as turning	○ Gained control over and confidence in body's ability
	Facial expressions and body language (other observations)	smiling, determination, proud and excited	○ Improving self-esteem
Participant reflections in personal DMT Journey Journals	Feelings at the start of the session	good; okay; very full; it's my birthday; I enjoyed myself; I passed my maths test; feel positive about tests I wrote; I ate a lot; I had a wonderful day	○ Influence of daily events on self-esteem ○ Influence of the wider social system ○ Social aspect of self-esteem
	Most positive aspect about the session	dancing together; joining our movements; this session was lots of	○ Increased group cohesion ○ Important role of the group ○ Social aspect of

		fun, I liked the poem and dancing together	○ self-esteem ○ Accepting and ability-promoting environment
	Most challenging part of the session	remembering all the moves	○ Uncertain ○ Insecure
	Self-discovery	I discovered I can dance a long sequence of movement; I discovered we are good at putting a dance together and we are all good dancers; dancing and being there for others is my strength; I enjoy and am good at other things than just writing poems and stories; I am good at moving; I have reason to love myself; I am brave	○ Improvement in self-esteem ○ Social aspect of self-esteem ○ Feel valued because they can support group members ○ Psychological aspect of self-esteem ○ Process of transcendence
	Peer contributions	encouragement makes me feel more able; they did not judge my movement or the way I did theirs; they showed me the right way of doing their moves; they smiled at me and cheered for me	○ Value encouragement from others ○ Positive interactions ○ Important role of the group ○ Social aspect of self-esteem ○ Increased group cohesion ○ Accepting and

			ability-promoting environment
	Participant contribution	encouraging others makes me feel good; I joined them when they were dancing in a circle; I was there to support and cheer for them	○ Feel valued because they can support group members ○ Positive interactions ○ Accepting and ability-promoting environment ○ Social aspect of self-esteem ○ Improving self-esteem
	End of the session	happy; excited; good	○ Improving self-esteem
Process notes in researcher's diary	Movement	challenge them one last time to give them an opportunity to experience success; individual movement sequences that transpire from each stanza speak of personal revelation: sweeping, releasing, big and open movements – not to mention original; expressive enough to convey message without using words, but also performance worthy; As they repeated it and gained confidence in what they were doing, movements became even stronger and more defined; they	○ Process of transcendence ○ Progression in movement ○ Familiar ○ Gain confidence ○ Experience success ○ Improving self-esteem

		asked to do it to music, but their movement was based on the rhythm of a poem, so they struggled to make the counts work; they are more than capable of doing the piece to the music, but adapting the moves and counts to fit the music and then synchronizing the movements is something that does not happens in 15 minutes; difference between movement and performance comes in: movement is expressive and spontaneous while performance takes hours and hours, weeks and even months of practice; ended off the session with an experience of success as I read the poem with music in the background as they did their movement piece; free movement session was very liberating for each participant; Pantsula movements were especially prominent; Pantsula never featured during the other sessions, which makes me wonder about its expressive potential	○ Uncertain ○ Process of transcendence ○ Use of traditional African movement
	Additional notes	wish they could take the code of conduct out into real life; makes them feel safe;	○ Role of wider social system ○ Uncertainty ○ Insecurity

		inside-out approach towards the code of conduct: take the code of conduct out into the real world by applying it in their interactions with others and feel good about themselves for treating people in an exceptional way; realize how much they have mastered; how they overcame the uncertainty and nervousness they had at the commencement of the programme; it took strength and courage to overcome those fears and master each instruction presented to them; love the poem; it reiterates everything they think and feel when going out into society; really proud of what they had created; participants want to know why I choose the words I wrote on each of their	○ Process of transcendence ○ Role of wider social system ○ Uncertainty ○ Insecurity

		respective certificates; many false compliments they might have heard before; consider higher order vocabulary of "Invictus"; difference between movement and performance art; after executing the curtsey and vocalising the meaning thereof, the group spontaneously gathered for a group hug; macro system is not informed about or prepared for persons with visual impairment; connection between psychological and social aspects of psychosocial wellbeing and how self-esteem plays a determinant role in psychosocial wellbeing; experiencing success contributes to self-esteem and subsequent	○ Language proficiency ○ Established group cohesion ○ Important role of the group ○ Accepting and ability-promoting environment ○ Psychological aspect of self-esteem ○ Social aspect of self-esteem ○ Gain confidence ○ Experience success ○ Improving self-

		psychosocial wellbeing; feel this way inside the accepting and secure space of the group; still not sure about whether they will be able to handle the outside world's uninformed and unprepared thoughts, behaviour and infrastructure; much more to be done in terms of family and community education and transformation; programme holds so much more potential for expansion and elaboration – to include more personal preparation and skill equipment to handle the outside world for the participants/clients but to involve their micro and macro systems as well	esteem o Important role of the group o Accepting and ability-promoting environment o Role of wider social system

Addendum W: Categories of data codes

CODES	KEY/IMPORTANT/REMAINING	THEMES
○ Low self-esteem ○ Scared of self-esteem being broken down further ○ Uncertainty ○ Insecurity ○ Fear of the unknown ○ Unsure ○ Restricted movement ○ Afraid to trust ○ Afraid of being judged ○ Psychological aspects ○ Physical aspects ○ Social aspects	KEY	Theme 1: Indications of low self-esteem prior to and during the DMT intervention programme
○ Influence from wider social systems ○ Influence of daily events on self-esteem ○ Feel valued when they can support others ○ Need for independence ○ Need support ○ Social aspect of self-esteem	IMPORTANT	Theme 2: The significant role of the micro and macro systems on self-esteem
○ Security of the group ○ Value encouragement from others ○ Accepting and ability-promoting environment ○ Feel valued because they can support group members ○ Positive interactions ○ Social aspects of self-esteem	IMPORTANT	Theme 3: The relevance of conducting this particular DMT intervention programme in a group format
○ Improving self-esteem ○ Progression in movement ○ Change in movement patterns ○ Gain confidence ○ More familiar ○ More certain ○ Less uncertain and unknown ○ More planned in nature ○ Feeling more capable	KEY	Theme 4: Indications of improvement in self-esteem during and at the end of the DMT intervention programme

○ Experience success ○ More control ○ More relaxed ○ More confidence ○ Enjoyment		
○ More familiar ○ More certain ○ More control ○ Process of transcending (being challenged and experiencing success) ○ Collaborative and individual movement ○ Experience success ○ Skill-building ○ Positive interactions ○ Feel valued when they can support others ○ Psychological aspects ○ Physical aspects ○ Social aspects	IMPORTANT	Theme 5: Main contributing factors to improved self-esteem
REMAINING CODDES		
Language proficiency	Link between Life Skills and DMT	Use of traditional African movement
Group compilation	Effective facilitation	

Addendum X: Registration letter

Postgraduate letter

M mandd@unisa.ac.za
Wed 04/11, 12:19 PM
MICHELLE BOTHA

Reply all |

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Dear Student

I wish to inform you that your registration has been accepted for the academ
ic year indicated below. Kindly
activate your Unisa mylife (https://myunisa.ac.za/portal) account for future
communication purposes and access to
research resources. Please check the information below and kindly inform the
Master's and doctoral section on
mandd@unisa.ac.za on any omissions or errors.

DEGREE : MED (SP IN GUID. & COUNS.) (98439)

TITLE : Dance movement therapy and the Psychosocial well-b
eing of learners with visual
impairment: A case study

SUPERVISOR : Prof D KRUGER

ACADEMIC YEAR : 2018

TYPE: SHORT DISSERTATION

SUBJECTS REGISTERED: DLGDC95 MEd - with specialisation in Guidance and
Counselling

A statement of account will be sent to you shortly.